

*Nutrition Section  
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## Infant and Young Child Feeding Programme Review

# Case Study: Benin



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## Acknowledgements

This case study is part of a review of infant feeding programmes which was conducted as a joint effort between UNICEF's Nutrition Section and the Academy for Educational Development (AED), in order to understand the factors that influenced breastfeeding programme outcomes, distil general lessons learned from the experience of these countries and make recommendations for programming on infant and young child feeding. The review included detailed individual case studies from six countries, as well as a consolidated report which draws upon these case studies. The six countries are Bangladesh, Sri Lanka, Uganda, Benin, the Philippines and Uzbekistan, chosen to represent a range of regions and diverse scenarios in terms of breastfeeding programming efforts and outcomes.

On the part of AED, the review was led by Luann Martin. Ann Brownlee visited Benin and prepared this country case study report.

In Benin, Dr. Paul Adovohekpe, Health Specialist for UNICEF-Benin, and Ms. Anne-Sophie Le Dain, nutrition programme officer from UNICEF's Regional Office in Dakar provided very helpful technical guidance during the visit and Dr. Souleymane Diallo, UNICEF Representative, provided strong inspiration and leadership during the review and planning process. Dr. Dominique Robez-Masson gave very useful technical and logistical support. Interviewees from the Directorate of Family Health at the MOH, the Directorate of food and Applied Nutrition (DANA) at the Ministry of Agriculture, Livestock and Fisheries, WHO, IBFAN, and health and social service facilities in Porto Novo, Abomey, and Adja-Ouere, as well as consultants for the World Bank and former staff of the MOH and the BASICS Project were generous in sharing their experiences and suggestions. Dr. Victor Dossou and Dr. Denis Mikode provided very useful insights. And, finally, many of the respondents above gave their time and provided very useful suggestions for future programming during a productive working meeting on the final day of the visit.

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## Acronyms and abbreviations

<b>BASICS</b>	Basic Support for Institutionalizing Child Survival
<b>BF</b>	breastfeeding
<b>BFHI</b>	Baby-friendly Hospital Initiative
<b>DANA</b>	Directorate of Food and Applied Nutrition (Direction de l'Alimentation and de la Nutrition Appliquée)
<b>DDS</b>	Departmental Directorate for Health ( <i>Direction Départementale de la Santé</i> )
<b>DHS</b>	Demographic and Health Survey ( <i>Enquête Démographique et de Santé</i> )
<b>EBF</b>	exclusive breastfeeding
<b>ECOWAS</b>	Economic Community of West African States
<b>ENA</b>	Essential Nutrition Actions
<b>FECECAM</b>	Fédération des caisses d'épargne et de crédit agricole mutuel
<b>HIV/AIDS</b>	Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome
<b>HRBAP</b>	human rights based approach to programming
<b>IBFAN</b>	International Baby Food Action Network
<b>IEC</b>	Information, education and communication
<b>IMCI</b>	Integrated Management of Childhood Illness ( <i>Prise en Charge Intégrée des Maladies de l'Enfant</i> )
<b>IYCF</b>	infant and young child feeding
<b>MDGs</b>	Millennium Development Goals ( <i>Objectifs du Millénaire pour le Développement</i> )
<b>MOH</b>	Ministry of Health ( <i>Ministre de la Santé</i> )
<b>NGO</b>	Non-Governmental Organization
<b>OMS</b>	Organisation Mondiale de la Santé
<b>ONUSIDA</b>	Programme commun des nations unies sur la VIH/SIDA
<b>PADME</b>	Projet d'appui au développement des micro-entreprises
<b>PMTCT</b>	Prevention of mother-to-child transmission (of HIV) ( <i>Prévention de la Transmission de la Mère à l'Enfant</i> )
<b>PMA/Nut</b>	Paquet Minimum d'Activités de Nutrition
<b>PNLS</b>	National Program to Combat AIDS
<b>PROFILES</b>	Nutrition advocacy tool
<b>PROSAF</b>	Promotion Intégrée de Santé Familiale (Projet)
<b>UNDP</b>	United Nations Development Programme
<b>UNICEF</b>	United Nations Children's Fund (Fonds des Nations Unies pour l'Enfance)
<b>UNICEF/NY</b>	UNICEF/New York (Headquarters)
<b>USAID</b>	United States Agency for International Development
<b>VIH/SIDA</b>	HIV/AIDS
<b>WHO</b>	World Health Organization

## Executive summary

This case study is one of six in a review of the contributions of UNICEF and its partners to infant and young child feeding (IYCF). The Benin study involved a review of relevant documents, a visit to Benin from November 3-8, 2008, interviews with 31 key informants<sup>1</sup>, and a stakeholder workshop. It was decided, for Benin, that the review would cover the last 15 years.

**Infant and young child feeding (IYCF) trends.** Benin had quite low exclusive breastfeeding rates in the early 1990s, like many countries in West Africa, but has had one of the highest average yearly rates of increase (3.4%/year), with only Ghana improving at a faster average yearly rate (4.7%/year) based on DHS trend data. Benin had only 10% exclusive breastfeeding in 1996 but increased substantially to 38% in 2001 and then to 44% in 2006. Rates of early initiation of breastfeeding (within the first hour) rose strongly during the same period, from 24% to 49% and 54% respectively. The bottle-feeding rates, only 5% for infants 4-6 months of age in 1996, rose to 24% in 2001, then leveling off at 22% in 2006 – indicating that this practice has begun to pose a greater danger than before. Complementary feeding, according to some indicators, has become more of a problem. Rates of breastfeeding with complementary foods for children 7 – 9 months of age<sup>2</sup>, recommended starting at 6 months of age, for example, have decreased, from 98% for 1996 to 88% for 2001 and 84% for 2006. Almost one-third of children between 6-23 months of age in 2006 did not meet the minimum standards for three indicators: consumption of breast milk or other milk, food diversity, and feeding frequency. This explains in part the continuing high rates of malnutrition in Benin. The percentage of children with moderate and severe stunting has actually risen, for example, from 25% in 1996 to 27% in 2001 and 35% in 2006.

**Accomplishments.** Several Ministries, through the years, have been tasked with nutrition-related mandates, including breastfeeding promotion and control of micro-nutrient deficiencies and malnutrition, with minimal coordination among the various initiatives. In the early 1990s Benin became active in the Baby-friendly Hospital Initiative (BFHI), with 26 maternity facilities designated by the mid 1990s and currently 27 designated, with 12 of the maternities in hospitals and 15 in health centers.<sup>3</sup> The rate of institutional delivery is 78%. However, the BFHI was not well-institutionalized in the national health system, with little training and no monitoring and reassessment, and thus as support from the international agencies (UNICEF and WHO) reduced, so did focus on this Initiative in Benin. This resulted in slippage in compliance. New initiatives such as the Integrated Management of Childhood Illness (IMCI) included some focus on IYCF practices, but only for sick children, until the IMCI-community initiative was introduced.

In 1998 the BASICS Project began working with the Departmental Directorate in the Borgou region, one of the most disadvantaged areas in the country, to launch the Minimum Package of Essential Nutrition Actions (Paquet Minimum d'Activités de Nutrition or "PMA/Nut" Project). This project, which focused on an integrated package of six "nutrition actions", including exclusive breastfeeding and complementary feeding with continued breastfeeding, was very creative in its approaches, with strong involvement of decision-makers from departmental to community level, innovative communication strategies, and strong facility and community components. Evaluations showed that exclusive breastfeeding (0-6 months) rose from 19% in the 1996 DHS to 60% in the 2002 PROSAF study, a much faster increase than for the country as a whole. A concentrated effort was made to plan for scaling up this integrated approach to achieve national coverage, with only partial success, due to changes in key staff in the MOH and USAID and lack of sufficient resources.

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<sup>1</sup> 28 interviews were completed during the field visit, two more in the U.S. and one by e-mail.

<sup>2</sup> The DHS reports on breastfeeding with "supplements", which have been termed as "complementary foods" here. While the DHS reports rates for the age group of 7-9 months, WHO recommends that feeding of complementary foods begin at 6 months of age.

<sup>3</sup> UNICEF's records indicate that there are 106 hospitals in Benin. There were 588 public maternities in health centers, according to "Annuaire statistiques 2007", but some of the health centers are now first referral hospitals. Statistics on the number of private maternities are not available. UNICEF and the MOH report that it is not possible to determine what proportion of institutional deliveries take place in baby-friendly facilities.

Various counseling approaches have been used throughout the period studied, with counseling at health and social service centres. In-service training using the “40 hour” Breastfeeding Counseling Course, the PMA/Nut training modules and flip charts, and other materials reached part of the health workers targeted. Pre-service education programmes such as those in schools of medicine, nursing and midwifery cover IYCF topics but in a very rudimentary fashion, with limited opportunities for clinical practice.

A number of community outreach strategies have been used by various Ministries and projects, both for breastfeeding promotion and complementary feeding initiatives, including rehabilitation of malnourished children. Various types of mother support groups have been used throughout the years, with varying success.

Communication strategies focused on group talks and airing of radio and TV spots at various times, and heightened focus on breastfeeding promotion during World Breastfeeding Week.

While maternity legislation, in principle, is somewhat generous (14 weeks with full pay) and self-employed women such as market women and artisans traditionally have taken three months leave from work, this is getting harder in today’s economy and women in the informal and private sectors cannot take advantage of the maternity regulations. No efforts have been made to provide “breastfeeding rooms” in offices or public places, except at UNICEF. Benin has a national Code of Marketing of Breastmilk Substitutes, the Decree passed in 1997, which led to less marketing and donations of formula in health facilities, but enforcement is difficult in the informal market economy. The Decree is somewhat out of date and is currently being revised. At present there is no active monitoring and enforcement of the Decree.

Benin is making a concerted effort, with the help of UNICEF and other donors, to raise the awareness of the dangers of HIV/AIDS, although prevalence rates are still low at 1.8% for adults. Work on the prevention of mother-to-child transmission (PMTCT) started in 2000 and is expanding, with some efforts underway to provide counseling for HIV positive women on infant feeding options.

**Factors contributing to results and current opportunities.** Strategies and programmes that are likely to have had a strong effect of IYCF-related indicators have included the concentration on implementing the “Ten Steps” within the Baby-friendly Initiative from 1993 to 1996/7, the emphasis on promotion of improved IYCF practices with the PMA/Nut programme first in Borgou from 1997-2003 and then more widely through a partial scale-up from the early 2000’s on. Promotion of exclusive breastfeeding as a strategy for preventing diarrhea within the national diarrheal disease programme spread the message farther. There has not been a similar emphasis on complementary feeding practices in recent years, and data show that progress in this area has been much slower with some of the available indicators, such as those for stunting, actually showing a worsening situation.

Recently, with the development and endorsement of the Global Strategy for IYCF in 2002 and advocacy at international level for national development of IYCF strategies and action plans, Benin, along with many other nations, has begun to work to strengthen this aspect of its nutrition programming. The Government of Benin is going to establish the High Council on Food and Nutrition (*Haut Conseil de l’Alimentation et de la nutrition*) with World Bank support and plans to set up a National Food & Nutrition programme. A national nutrition policy will be developed in 2010. These new developments are an important opportunity for the MOH, UNICEF and other partners to put nutrition and IYCF at the front of the development agenda in Benin.

**Remaining challenges.** A number of problems still need to be addressed if IYCF practices are to continue to improve. They include:

- The persistence of traditional practices such as giving babies herbal teas (*tisanes*), water and other foods at a young age, that continue to slow the adoption of exclusive breastfeeding.
- Increasing bottle-feeding and formula feeding, with poorly regulated marketing of breast-milk substitutes and Code violations.

- Lack of sufficient qualified health personnel and limited breastfeeding management skills among those available.
- The irregularity and poor quality of support, supervision and monitoring of staff tasked with IYCF-related responsibilities and lack of clarity in the duties of staff at different levels.
- Rapid turnover of management, health facility, and community-level staff and volunteers, making the task of providing sustained IYCF-related support, promotion and protection a major challenge.
- Inadequate emphasis on IYCF by the Ministries and various partners, limited resources and coordination, vertical programming, and lack of integration of IYCF activities with other health and nutrition responsibilities at various points of contact, resulting in less cost-effective care.

**Recommendations.** The following recommendations are based on document review, key informant interviews, and the stakeholder meeting at the conclusion of the country visit.

- Work closely to finalize an IYCF Action Plan well coordinated with the multisectoral food and nutrition programme as key aspects of a more fully integrated, results-based nutrition programme. Consider strategies for “going to scale” with cost-effective approaches.
- Designate a working group to guide the development of an updated IYCF policy in line with the latest international recommendations and an integrated IYCF strategy with representation from the key Ministries, UNICEF, WHO, the World Bank, NGOs, and bilateral aid programmes that could lend support. UNICEF, along with other partners, could provide the resources needed for sustained coordination.
- Support the development of high level advocacy strategies to increase decision-maker awareness of the essential contributions of IYCF programming to development, using an updated PROFILES tool, the BFHI Course for Decision-makers and other available mechanisms.
- Finalize the revision of the National Code (Decree) on the Marketing of Breast-milk Substitutes (Décret No. 97-643), updating exclusive breastfeeding recommendations and including guidance for infant feeding practices in difficult circumstances such as HIV/AIDS and emergencies, designate an active interagency code monitoring group, and implement a process for monitoring and reinforcement of the Code, with provision of needed resources.
- Reactivate a Coordination Committee for BFHI and undertake an evaluation of the present status of BFHI and implementation of the “Ten Steps” in all facilities. Develop a simplified set of materials and systems for training, assessment and monitoring, taking advantage of the newly revised BFHI package. Explore strategies for ensuring that BFHI is integrated into the national health system, with national ownership and support for the process. Consider strategies for integrating BFHI assessments into current hospital accreditation mechanisms. The BFHI should be part of standard hospital operating and supervision procedures.
- Explore strengthening of health system counseling and support for breastfeeding and complementary feeding beyond maternity facilities, through further integration of IYCF support during well-baby visits, sick child consultations, immunization sessions, growth monitoring, and other points of contact, both in hospitals and health centers at various levels.
- Consider, when developing an integrated programme, how best to design the community level approaches, starting with a review of what strategies have been used in the past and which have and have not worked and why. Review strategies for peer counseling, mother support groups, and effective community-level communications, considering the work of such programmes as PMA/Nut, Freedom from Hunger’s Credit with Education Program, The Grandmother Project, and others. Stress participatory approaches that actively engage the community in planning, implementing and evaluating initiatives to improve IYCF practices.
- Develop and implement an evidence-based national communication for development strategy using multiple channels.

## **1. Introduction**

At the global level, improving infant and young child feeding (IYCF) practices (breastfeeding and complementary feeding) has been identified as the single most important child survival intervention of an essential package of child survival interventions recommended for implementation at scale in low-income countries with high malnutrition and mortality rates in children. Breastfeeding promotion and complementary feeding are integral elements of the child survival approach, with the potential to contribute a substantial reduction in child mortality<sup>4</sup>. Despite the evidence, IYCF receives far less attention and funding than it deserves.

This case study is one in a series of six in a study commissioned by the United Nations Children's Fund (UNICEF) to review the contributions of UNICEF and its partners to infant and young child feeding over the past few years. The other countries studied include Bangladesh, the Philippines, Sri Lanka, Uganda, and Uzbekistan. The aim of the IYCF review was to: 1) better understand the contextual and programmatic factors that led to the changes in selected countries; 2) assess the contributions by different actors, including UNICEF, to the area of IYCF during the period when the change in breastfeeding rates occurred; 3) develop a series of innovations, good practices and lessons learned to improve future programming, and 4) identify ways of overcoming challenges to improved practices. UNICEF/NY requested that this review focus, for the most part, on breastfeeding and key indicators, such as exclusive breastfeeding, related to this practice, while recognizing that the improvement of complementary feeding practices and foods is also an essential component of a comprehensive IYCF strategy. It was decided, for Benin, that the review would cover the last 15 years, since the trend data of interest came from the 1996, 2001 and 2006 national Demographic and Health Survey (DHS) reports.

The development of the case study for Benin involved review of relevant documents, a field visit between November 3 – 8, 2008 to Cotonou, Benin, and analysis of the information and data obtained before and during the visit (See documents reviewed in Annex 1). The field work included interviews of 28 key informants, involving staff from UNICEF, the World Health Organization (WHO), the Ministry of Health (MOH), various partners, community volunteers, and one mother support group. Two additional interviews were conducted in the U.S. and one questionnaire completed by e-mail. (See Interview Schedule in Annex 2.)

In addition, a 6-hour workshop was held the final day of the visit, which focused on a review of IYCF trends. Working groups discussed development and advocacy for IYCF policies, IYCF at institutional level, and IYCF at community level. Each of the three groups worked to identify the key milestones and accomplishments in their focus areas, the challenges and how they had been addressed, strategies for sustainability and what worked, lessons learned, and recommendations for the future. The workshop ended with group reports and finalization of recommendations.

## **2. Country profile**

### **2.1 Demographic, health and nutrition indicators**

Benin is a lower income country with a population of about 9 million in West Africa, has 42 ethnic groups and a substantial nomadic population in the north.

It has a low life expectancy at birth (55.4 years), a low adult literacy rate (34.7%) and a human development index of .43, ranking 163 out of 177 countries. Its economy is underdeveloped, with almost three-quarters of the population coping on less than \$2 a day.

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<sup>4</sup> The *Lancet* 2003 Child Survival series estimates that with 90 percent coverage of exclusive breastfeeding for the first six months and 90 percent coverage of continued breastfeeding to 12 months, child mortality could be reduced by 13 percent. It also estimates that timely and appropriate complementary feeding could avert 6 percent of under-five deaths. The *Lancet* 2008 Nutrition Series estimates that optimal breastfeeding practices up to 2 years could potentially save 1.4 million lives annually.

Benin's prospects for achieving most of the Millennium Development Goals (MDGs) are slim, except for education and provision of safe drinking water. Increased development assistance and better governance with less corruption and increased transfer of resources to the local level are needed to empower the population and achieve the MDGs.

The coverage of the health sector is reasonably high, with 88% of mothers receiving antenatal care and 78% delivering in health facilities. Adult HIV prevalence remains low for now, at 1.8%. However, Benin is not on track to meet the MDG targets for the Under Five Mortality Rate (reduction by 2/3rds between 1990 and 2015), with the 2006 rate only 20% lower than that in 1990. The Infant Mortality Rate (IMR) in 2006 was only 21% lower than that in 1990. However, the rates of decrease improved substantially between 2001 and 2006, making attainment of the targets more likely.

Child malnutrition has remained a significant problem in Benin, with moderate and severe stunting increasing substantially (from 25% in 1996 to 27% in 2001 and then 35% in 2006) and wasting and underweight percentages only decreasing slightly.

The rate and direction of changes in key IYCF indicators have varied, as will be discussed in the "Results" section. The key breastfeeding indicator (exclusive breastfeeding < 6 months) increased dramatically from 10% in 1996 to 38% in 2001 and then 44% in 2006. (See Table 1 at right and Table 2 in the "Results" section.) Benin is one of 13 countries worldwide that increased exclusive breastfeeding rates among children under 6 months old by more than 20 percentage points between 1996 and 2006.

The experience of Benin shows that sharp improvements in exclusive breastfeeding rates are possible. However, focus on activities for the promotion of improved breastfeeding practices have decreased significantly within the past few years. This IYCF programme review will identify the challenges encountered during the past 15 years in improving IYCF practices, the policies and programmes enacted to address these challenges, and the results that have been achieved. The review will also identify remaining gaps and recommend actions to move the IYCF agenda forward and contribute to achievement of Benin's Millennium Development Goals.

**Table 1. Benin Profile**

Indicator	Data
<b>Demographic indicators</b>	
Total population (millions)	9.0
Population under 5 (millions)	1.5
Urban population (%)	41
Total fertility rate	5.5
<b>Mortality indicators</b>	
Under-five mortality rate	123
Infant mortality rate	78
Neonatal mortality rate	36
<b>Nutrition indicators</b>	
Low birthweight (%)	15
Moderate and severe stunting (%)	35
Moderate and severe wasting (%)	8
Moderate and severe underweight (%)	23
<b>Infant feeding indicators</b>	
Exclusive breastfeeding (< 6 months) (%)	44
Breastfeeding with comp. foods (7-9 months) (%)	84
Still breastfeeding (20-23 months) (%)	57
<b>Health indicators</b>	
Adult HIV prevalence (15-49 years)	1.2
Antenatal care coverage (%)	84
Institutional deliveries (%)	78
Population using improved drinking water sources (%)	65
Population using adequate sanitation facilities (%)	30
<b>Human development indicators</b>	
Human development index (HDI) value	.437
Life expectancy at birth (years)	55.4
Adult literacy rate (ages 15 and older) (%)	34.7
Gross school enrollment (%)*	50.7
Gross Development Product per capita (PPP US\$)**	\$1,141

\*Combined primary, secondary, and tertiary gross enrollment ratio

\*\* Purchasing power parity

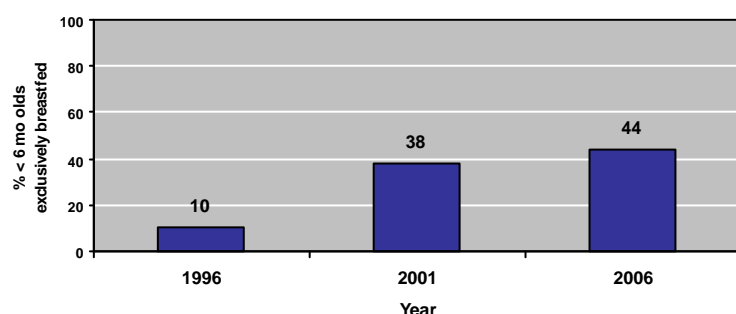
Sources: *The State of the World's Children 2009*, UNICEF; *DHS Report 2006*; Human development indicators:

<http://hdr.undp.org/en/statistics/>

## 2.2 Trends in breastfeeding rates in Benin

The Benin Demographic and Health Survey (DHS) reports from 1996, 2001 and 2006 provide data on IYCF trends. In the 24 hours prior to the survey, 10% of infants 0-5 months were exclusively breastfed in 1996. The exclusive breastfeeding rate increased dramatically to 38% in 2001 and then increased slightly to 44% in 2006 (Figure 1).

**Figure 1. Trends in Exclusive Breastfeeding in Benin**



Timely initiation of breastfeeding (within the first hour) rose with each survey, from 24% in 1996 to 49% in 2001 and 54% in 2006 with the largest gain (25 percentage points) between the first two surveys. The median duration of exclusive breastfeeding has also continued to increase, up from .5 months in 1996 to 1.9 months in 2006, but still has a long way to reach the optimal 6 months. The data on bottle feeding indicate that this is a problem

for infants 4-6 months of age, with rates increasing from 4% in 1996 to 24% in 2001 and then only slightly decreasing to 22% in 2006. Use of infant formula increased for children of all age groups between 1996 and 2001 and then, for 2006, decreased for children 0-3 months of age, while still going up slightly for the other age groups. Rates of breastfeeding with complementary foods for children 7 – 9 months of age, which is recommended for this age group, decreased from 98% in 1996 to 88% in 2001 and to 84% in 2006. This indicator only reflects timely initiation of complementary feeding. Other nutrition indicators suggest that there are still major challenges with complementary feeding, with stunting substantially increasing. (See Table 2 below.)

<b>Table 2. Breastfeeding and Nutritional Status Trends</b>	<b>1996 DHS</b>	<b>2001 DHS</b>	<b>2006 DHS</b>
Timely initiation of breastfeeding	24%	49%	54%
Exclusive breastfeeding (0-5 months)	10%	38%	44%
Median duration of exclusive breastfeeding	0.5 months	1.1 months	1.9 months
Median duration of breastfeeding	22.8 months	22.3 months	21.9 months
Bottle feeding (0-3 months)	4%	--	3%
Bottle feeding (4-6 months)	5%	24%	22%
Formula feeding (0-3 months)	3%	20%	10%
Formula feeding (4-6 months)	2%	18%	19%
Breastfeeding with complementary foods (7-9 months)	98%	88%	84%
Moderate and severe stunting (below -2 SD)	25%	27%	35%
Moderate and severe wasting (below -2 SD)	14%	10%	8%
Moderate and severe underweight (below -2 SD)	29%	24%	23%

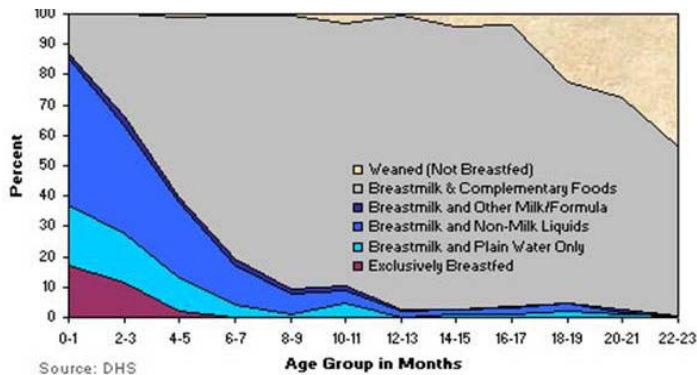
The new IYCF practices indicator is a composite indicator that reports on three practices among children 6-23 months old: 1) breast milk/other milk, 2) food diversity, 3) and feeding frequency. The results, only available in the 2006 DHS for Benin, indicate that only 32% of children in this age group met the *minimum* standard for all three practices. This explains in part the high rates of malnutrition among this age group and indicates the importance of improving food quality and feeding practices.

**Area graphs.** These graphics that have been produced for many DHS surveys are useful in showing visually the mix of feeding practices for various ages. They are available for Benin for all three of the

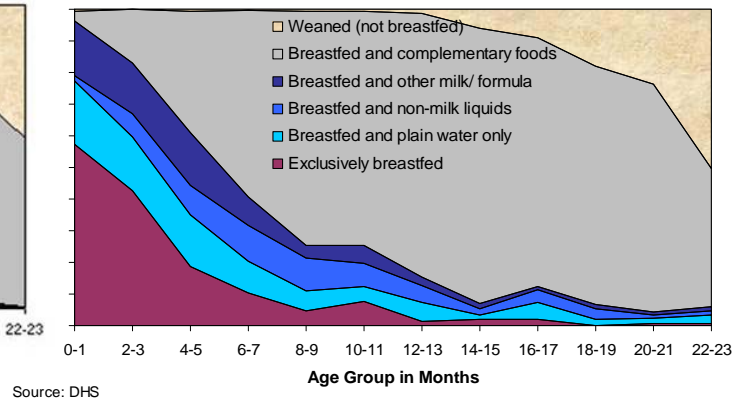
latest DHS reports. They show that exclusive breastfeeding (the area indicated in magenta) increased dramatically from 1996 to 2001 and continued to rise slightly more by 2006. The graphs also show that the practice of breastfeeding and giving non-milk liquids for the 0-5 month group is decreasing, while the practice of breastfeeding and giving other milks/formula has substantially increased for this same age group and older children from 1996 to 2001 and then decreased again in 2006. (See Figure 3 below.) The area graphs only report on what was fed and not on the quantity, quality, or frequency of the feeds.

**Figure 2. Comparison of breastfeeding practices by age, Benin 1996, 2001 and 2006.**

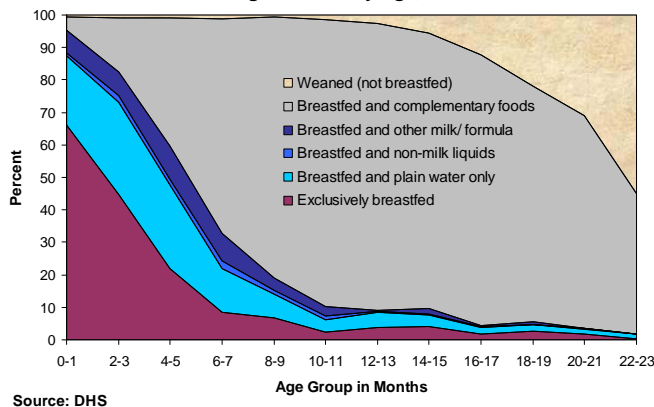
Breastfeeding Practices by Age, Benin 1996



Breastfeeding Practices by Age, Benin 2001



Breastfeeding Practices by Age, Benin 2006



### 3. Findings of the review

#### 3.1 IYCF situation assessments and challenges

##### *Needs assessments*

Several needs assessments focused on nutrition and IYCF have been completed in Benin through the years. For example:

- The LINKAGES Project and BASICS<sup>5</sup> completed a “Nutrition assessment for USAID/Benin” in 1997.

<sup>5</sup> The Basic Support for Institutionalizing Child Survival (BASICS) project.

- BASICS II completed a number of needs assessments, including a participatory situational analysis, baseline studies, development and testing of key tools, and trials of improved practices, and communications and health facility assessments among others, as part of the process of designing its “Essential Nutrition Actions” (ENA) strategies for the Paquet minimum d’activités de nutrition project (PMA/Nut) in Borgou.
- The « Promotion Intégrée de Sante Familiale dans le Borgou et l’Alibori » project completed a study, *Promotion Intégrée de Sante Familiale dans le Borgou et l’Alibori (PROSAF): Enquête sur l’allaitement maternel exclusif (Study of exclusive breastfeeding)* in 2001.
- The “Integrated Promotion of Family Health” project in Borgou and Alibori conducted a *Study of the beliefs, attitudes and practices related to family health (Enquête sur les Connaissances, Attitudes et Pratiques en Matière de Sante Familial)* in 2003.
- The World Health Organization and Ministry of Health commissioned an *Analysis of the situation of infant and young child feeding practices in the context of HIV/AIDS (L’analyse de situation des pratiques de l’alimentation du nourrisson et du jeune enfant dans le contexte du VIH/SIDA)* which was completed during a 10 day mission in 2006. The analysis, using the French version of the global “Infant and Young Child Feeding: National Tool for Assessing Practices, Policies and Programmes”, provided valuable data on the situation in Benin related to all aspects of the Global Strategy, key accomplishments thus far, aspects of the programme needing improvement, and recommendations to consider when developing the IYCF strategy and action plan.<sup>6</sup>

### ***Problems and challenges***

A number of problems that need to be addressed, if IYCF practices are to be improved, were identified, both in the needs assessments mentioned above and during interviews with programme managers and breastfeeding advocates. They include:

- Traditional practices that have interfered with good feeding practices, such as giving babies herbal teas (*tisanes*), water, and other foods at a young age and, on the other hand, failing to provide adequate complementary foods after six months of age or to feed properly when a child is ill.
- Complaints by mothers that they have insufficient breast milk due to lack of sufficient food for themselves<sup>7</sup> and lack of understanding that early initiation would help the milk come in.
- Increased bottle-feeding and formula feeding, especially after about 3 months of age, with poorly regulated marketing of breast-milk substitutes and Code violations.
- Lack of sufficient qualified health personnel and limited IYCF management skills among those available, with little understanding of how to integrate nutrition with their curative activities.
- The irregularity and poor quality of support, supervision and monitoring of staff tasked with IYCF-related responsibilities and lack of clarity in the duties of staff at different levels.
- Rapid turnover of management, health facility, and community-level staff and volunteers, making the task of providing sustained IYCF-related support, promotion and protection a major challenge.
- Hospital policies and practices not conducive to the establishment of good breastfeeding practices.
- Insufficient emphasis on IYCF-related community outreach and support.
- No support for breastfeeding mothers in the workplace.
- Inadequate political will and emphasis on IYCF by the Ministries and partners, limited resources, short-term initiatives dropped for other mandates without making sure approaches that have worked continue to be included, and lack of coordination among the various actors.

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<sup>6</sup> Ahouandjinou, H. *Rapport de l’analyse de situation des pratiques de ANJE*. June 2006, pp. 2-3.

<sup>7</sup> Research shows that maternal under-nutrition has little effect on the volume or composition of breast milk unless the malnutrition is severe. None-the-less, educational messages (not just targeted to the mothers but the wider families and communities) and counselling should emphasize that lactating women need extra food.

- Vertical programming and lack of integration of IYCF activities with other health and nutrition responsibilities at various “points of contact”, resulting in less cost-effective care and poorer impact.
- Challenges of working in a decentralized system and engaging communities, with some localities not yet aware of their potential for designing and activating high impact integrated strategies.

The next sections of the report address the response to these challenges.

### **3.2 Mobilization of partners and programme coordination**

#### *Mobilization of partners*

Mobilization and coordination of key partners and stakeholders has been an important aspect of the country’s efforts to improve IYCF practices, although much more needs to be done in this regard. The Government of Benin, as expected, has played the leading role, with key international organizations such as UNICEF, WHO and the World Bank providing substantial support. Partners involved in IYCF and other nutrition activities include:

- **Ministries of the Republic of Benin** that have a mandate for work in nutrition, including:
  - The Ministry of Health (Ministère de la Santé), through the Directorate of Family Health (Direction de la Sante Familiale - DSF), is the lead organization for maternal and infant health, and provides services related to nutrition, maternal and infant health, and family planning.
  - The Ministry of Agriculture, Livestock and Fisheries (Ministère de l’Agriculture de l’Elevage et de la Pêche - MAEP), and its Directorate of Food and Applied Nutrition (Direction de l’Alimentation and de la Nutrition Appliquée - DANA) have undertaken a number of key nutrition studies, developed nutrition courses and other tools, promoted family gardens, developed nutritional products (flours) for young children, worked on food security, and developed a community-based approach to nutrition through its regional centers
  - The Ministry of Family and National Solidarity (Ministère de la Famille et de la Solidarité Nationale) carries out much of the nutrition-related work in the field through its network of community outreach workers and Social Promotion Centres.
  - The Ministry of Decentralization, Local Governance and Regional Planning and various departmental directorates and health zones (Directions Départementales et Zones Sanitaires) and municipalities are involved in nutrition-related activities and programmes.
- **International organizations** include UNICEF and WHO, with their country offices taking the lead, and regional and headquarter colleagues providing additional assistance when needed. The World Bank, the African Development Bank, the Food and Agriculture Organization, the World Food Programme (WFP), the United Nations Fund for Population Activities (UNFPA), the Global Fund, and the Joint United Nations Programme on HIV/AIDS are also key international partners in the areas of nutrition, child survival, and feeding of children in difficult circumstances, providing both technical and financial assistance.
- **Bilateral donor organizations** include the US Agency for International Development (USAID), and the aid agencies of the Japanese, Belgian, Swiss and German governments, among others. USAID, for example, has funded the BASICS Project, Essential Nutrition Actions package (Paquet minimum d’activités de nutrition - PMA/Nut), the Promotion Intégrée de Sante Familiale (PROSAF) Project, the Projet Intègre de Sante Familiale (PISAF) and the Projet de lutte contre la malnutrition dans les zones déshéritées, all of which have focused to some extent on IYCF.
- **Non-governmental organizations (NGOs)** include groups such as the Infant Baby Food Action Network (IBFAN), support for Code monitoring and BFHI; Doctors Without Borders (Médecins sans Frontières), medical assistance in crisis situations; Plan Benin, support for PMTCT and counseling related infant feeding and HIV; Terre des Hommes, support for health centres and community outreach programmes; Catholic Relief Services (CRS), implementation and financing of the Food and

Nutritional Programme through the Social Promotion Centers; religious or “confessional” hospitals, supporting nutrition; and Freedom from Hunger, micro-credit programmes with health and nutrition education (“Credit with Education”) in collaboration with credit associations in Benin.

- **Professional societies** such as the Benin Pediatric Society, Society of Obstetricians and Gynecologists, Association of Midwives, and National Beninese Association of Nurses, are asked from time to time to orient their members to new IYCF guidelines and technical updates and provide technical expertise for various government initiatives.
- **The private sector** has grown rapidly since the mid 1980s. Currently about 60% of all health consultations in Cotonou are with private practitioners. The Ministry of Health suggests that there are important roles for the private sector in supporting IYCF-related policies and programmes.

#### *Programme coordination*

National committees have been organized to guide various aspects of IYCF and nutrition programming. When the BFHI was organized in the early 1990’s, a National BFHI Committee was designated by means of a ministerial decree and a coordinator appointed but, in recent years, this committee has been inactive for the most part. A National Committee for Food and Nutrition (CNAN) and coordinator were also designated, but have not been very energetic, partly due to lack of any control over how resources in nutrition are utilized. Currently there is lack of adequate coordination and collaboration among the various partners working on IYCF and nutrition.

### **3.3 IYCF policies, strategies and plans**

#### *Nutrition and IYCF-related policies*

During the World Summit for Children in 1990 Benin, along with 138 other nations, approved the Innocenti Declaration, which recommended that Governments develop national breastfeeding policies. The Global Strategy for Infant and Young Child Feeding (2002) directed national authorities to develop integrated IYCF policies. The IYCF situational analysis completed in Benin 2006 using the Assessment Tool for the Global Strategy, gave the country a “medium” score, on average, on development of national IYCF policies.<sup>8</sup> Benin’s key achievements in the policy area have included:

- Development of a *Declaration of a national policy for the protection, support and promotion of breastfeeding (Déclaration de politique nationale pour la protection, l’encouragement and la promotion de l’allaitement maternel)*, adopted in 1992.
- Adoption of a decree concerning organization and functioning of the National Committee for Food and Nutrition (Comite National pour l’Alimentation et la Nutrition -- CNAN) in 1994
- Adoption of a decree concerning the creation, composition, and functioning of a National Commission for Refugees (Commission Nationale chargée des Réfugiés) in 1997.
- Adoption of an order concerning the creation and nomination of members of the National Committee for Coordination of the Activities for the Baby-friendly Hospital Initiative (Comité National de Coordination des Activités pour l’Initiative Hôpitaux Amis des Bébé) in 1999.

The national breastfeeding policy, drafted more than 15 years ago, is not in conformity with current international standards. The international recommendation for the duration of exclusive breastfeeding is now 6 rather than 4 to 6 months, as stated in the older policy, and guidelines recommended in the Global Strategy for IYCF and more recent recommendations for feeding children in difficult circumstances

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<sup>8</sup> ANJE: Evaluation nationale des pratiques, des politiques et des programmes, MOH and WHO, 2004, pp. 11-13.

(emergencies and HIV)<sup>9</sup> are not addressed there either. The Ministry of Health is in the process of revising the policy.

National committees such as those for Food and Nutrition and for BFHI are currently not very active, according to the recent IYCF situational analysis.

### ***Maternity protection legislation***

Maternity protection legislation (*Loi N 98-004 portant code du travail en République du Bénin (Articles 170 à 173)*) currently includes the designation of maternity leave for up to 14 weeks (6 of which can be taken before delivery) and breastfeeding breaks (½ hour in the morning and ½ hour in the afternoon). These regulations are not always applied and they do not provide any relief for women working in the private or informal sectors. Breastfeeding breaks may be helpful to a few nursing mothers, but most are not able to keep their babies close enough to breastfeed during working hours and can only benefit from a slightly shortened day.

### ***IYCF strategies and plans***

Benin's political commitment to nutrition action started to consolidate in the early nineties when it sent a delegation to the International Nutrition Conference held in Rome in 1992. Nutrition plans developed in the 1990's included breastfeeding and complementary feeding components. The 10-year *National Plan of Action for Food and Nutrition* developed by DANA in 1995, for example, focused on breastfeeding and complementary feeding, as well as a very wide range of other actions affecting nutrition. Strategies related to IYCF included:

- Ensuring that all maternity services participate in BFHI, including all public and private services
- Enforcing the Code of Marketing of Breast-milk Substitutes
- Training or retraining health agents and others in appropriate weaning practices<sup>10</sup>
- Studying the obstacles to increasing breastfeeding and taking the necessary measures to raise it
- Managing disadvantaged groups nutritionally
- Preventing micronutrient deficiencies
- Promoting appropriate feeding and hygiene

In the early 2000s, a *Five-year Programme for Nutrition in the Health Sector 2001-2005 (Programme Quinquennal de Nutrition Sector Sante 2001 – 2005)* was developed. This plan was much more narrowly focused on PMA/Nut.

Following the endorsement of the *Global Strategy for IYCF* by the World Health Assembly and the UNICEF Executive Board in 2002, WHO and UNICEF organized two meetings, in Ouagadougou in 2005 and Cotonou in 2005, to encourage the countries in the African region to develop IYCF plans, strategies and action plans.

The first *National Strategy for IYCF (Stratégie nationale ANJE)* was then prepared by Benin for the years 2005-2008, accompanied by a plan of action and budget.

A second multi-year comprehensive IYCF strategy and plan, *Stratégie Nationale pour l'Alimentation du Nourrisson et du Jeune Enfant: 2008 – 2013*, is currently being drafted. The general objective of the National Strategy is to improve, by optimal feeding practices, the nutritional status, growth, development, health and survival of infants and young children and the mothers of Benin. Its key strategic components include:

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<sup>9</sup> For example, the "Updated HIV and Infant Feeding recommendations, based on 2000 and 2006 technical consultations", found in Annex 1 of WHO (2007) *HIV and Infant Feeding Update* ([http://whqlibdoc.who.int/publications/2007/9789241595964\\_eng.pdf](http://whqlibdoc.who.int/publications/2007/9789241595964_eng.pdf), and IFE Core Group (2007) *Operational Guidance on Infant and Young Child Feeding in Emergencies*, v2.1 (<http://www.enonline.net/resources/view.aspx?resid=6>)

<sup>10</sup> Note: The word "weaning" is no longer used in relation to general introduction of complementary foods.

1. Promotion of appropriate feeding for infants and young children
2. Infant and young child feeding and HIV
3. Safe and adequate feeding of infants and young children in difficult circumstances
4. Strengthening of institutions and their strategies
5. Development of a plan for communication to improve practices
6. Promotion of maternal nutrition
7. Promotion of research related to IYCF
8. Monitoring and evaluation of the implementation of the national IYCF strategy.

The draft Strategy describes the technical considerations that should be kept in mind when developing plans related to each of these strategic components. A detailed plan of action and budget for each of the components and guidelines for monitoring and evaluation of the plan are also in the process of being finalized. The document spells out the responsibilities of the Government and key partners necessary to realize the plan and will be used to mobilize technical and financial support from donors.

### ***Initiative for an integrated nutrition approach with high level political support***

Finally, the Government of Benin is currently establishing the High Council for Food and Nutrition (*Haut Conseil de l'Alimentation et de la nutrition*) with the World Bank's support, with the Decree signed by all key ministers and the President. Dr. Joseph Hessou is working as chief of the CORE Group working to organize this important initiative to place nutrition squarely at the center of the development process. A multi-sectoral food and nutrition programme is being drafted. The "Programme National de Nutrition axe sur les Resultats" (PNAR) will be validated in May 09 (Workshop: May 25-29 with Government agencies, nutrition partners and the World Bank). UNICEF is actively involved in this high level process. This initiative will reinforce coordination, build on synergies and ensure an optimal utilization of resources for nutrition. This is an opportunity to accelerate the scaling-up of high impact nutrition interventions in Benin.

### ***UNICEF IYCF programmes***

UNICEF programmes, through the years, have included a strong focus on primary health care and later child survival strategies that have emphasized, as one component, the promotion, support and protection of breastfeeding and improved complementary feeding practices. UNICEF-Benin supported the elaboration and passage of the national Code (Decree) on the Marketing of Breast-milk Substitutes in 1997 and the launching of the Baby-friendly Hospital Initiative in Benin, in 1992, both of which will be described below. In the late 1990's and early 2000's UNICEF helped support the PMA/Nut strategy in Borgou and the other health zones where its programming was focused. Since the Global Strategy for IYCF was endorsed at the international level, UNICEF has worked closely with the Benin Government and its Ministries, along with WHO, to provide encouragement and technical assistance for the development of the IYCF strategies and plans described above.

The UNICEF programme for 2004 – 2008 had three main sectoral projects (survival, education and protection), two cross-cutting programmes (young childhood and HIV/AIDS) and two cross-cutting programmes for support (follow-up and evaluation, and information-communication). The "survival" project had three sub-projects (Expanded Promotion of Immunization (EPI), Integrated Management of Childhood Illness (IMCI) and Nutrition). The Nutrition sub-project, which had expenses of \$2,278,537, emphasized training of community-based workers (Agents de Service à Base Communautaire) and health agents on the Essential Nutrition Actions Package (PMA/Nut) and implementation of this project, with 223,571 USD budgeted for PMA/Nut<sup>11</sup> during this 4 year period. UNICEF supported PMA/Nut in 42 out of 77 communes (55%). The HIV/AIDS programme included a prevention of mother-to-child transmission of HIV (PMTCT) component and activities to strengthen the care of infants born to HIV positive mothers.

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<sup>11</sup> This total does not include the expenses for mass campaigns.

UNICEF-Benin has elaborated its 2009-2013 Cooperation Programme, integrating a strong nutrition component. The recently adopted 2009-2013 Child Survival and Development (CSD) programme has five interdependent pillars aimed at the reduction of under-five and maternal mortality by supporting efficient interventions and sustained quality services for mothers, newborn and children at both community and facility levels. UNICEF-Benin has shown its commitment in the nutrition field by making nutrition one of the five pillars of this CSD 2009-2013 cooperation programme. The nutrition component focuses on the window of opportunity for nutrition and emphasizes the key role of optimal infant and young child feeding practices for child survival and development. The promotion of adequate infant and young child feeding practices is integrated in a comprehensive strategy that encompasses health, nutrition, WASH, HIV/AIDS as stated in the Child Survival for development package.

The nutrition component will focus on provision of the minimum nutritional package, micronutrient deficiencies control and the promotion of exclusive breastfeeding and better feeding practices for young children. The programme will also assist the government in the development and implementation of the strategy for IYCF. Management and prevention of acute malnutrition will be given particular attention.<sup>12</sup> The HIV/AIDS programme will strive to continue to strengthen PMTCT services, focusing on 18 out of 34 health districts, and support will be given in emergency situations, with nutrition in emergencies, including IYCF, given particular attention. A more integrated approach to “essential practices” is being pursued, focusing on “Essential Practices for the Feeding and Nutrition of Women, Infants and Young Children” (Pratiques Essentielles pour l’Alimentation et la Nutrition de la Femme, du Nourrisson et du Jeune Enfant), which combines PMA/Nut, maternal nutrition and HIV/AIDS. The 2009 UNICEF Nutrition budget (including direct/indirect IYCF activities) is around 1,500,000 USD.

UNICEF Benin’s commitment to nutrition is also reflected in the new office structure with the creation of two positions. A national Nutrition Officer is stationed in Northern Benin and the international Nutrition Specialist will be stationed in Cotonou. The national officer is now operational and the international officer should be recruited during the first semester of 2009. The officers will work in close collaboration thus being able to support both policy development and programme implementation work effectively.

All of the above developments show that the importance of nutrition for health and development is now increasingly recognized in Benin. UNICEF-Benin would like to seize this opportunity to further expand its collaboration with key strategic partners in nutrition toward achieving common goals and put nutrition at the forefront of the development agenda in Benin. UNICEF, nutrition partners and the government will work at both upstream (policy development) and downstream (programme implementation) levels.

### **3.4 Key components of the breastfeeding and IYCF programmes**

#### ***Policy level advocacy***

Benin applied the PROFILES nutrition advocacy process in January 2004 with support from USAID. PROFILES aims to improve nutrition through analysis, advocacy and programme planning using computer-based software and an advocacy process that helps make the case for improving nutrition. The PROFILES workshop in Cotonou brought together a multi-sectoral group of 13 professionals, each from a different key ministry. The workshop focused on building an understanding of the scientific basis of the PROFILES estimates of the consequences of malnutrition and sub-optimal breastfeeding, reaching a consensus on the data and technical arguments used and on the advocacy objectives, messages and audience, developing a PROFILES advocacy presentation, and developing a longer-term strategy for nutrition and breastfeeding advocacy.<sup>13</sup>

The PowerPoint PROFILES presentation, “*Ensemble, Investissons dans la Nutrition pour Reduire la Pauvrete*” (Together Let’s Invest in Nutrition to Reduce Poverty), focuses on malnutrition and its signs

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<sup>12</sup> From “UNICEF current draft country program document.pdf”, p. 8-9.

<sup>13</sup> Stiefel H. and K. Samba, “Trip Report, Benin PROFILES Workshop, January 19-30, 2004. Food and Nutrition Technical Assistance (FANTA), Academy for Educational Development, Washington D.C. 2004.

and causes, and the consequences of nutritional problems in the key sectors of health, education and the economy. It features the problem of inadequate breastfeeding, and the fact that annually over 1700 deaths of children under one year of age including can be directly attributed to it<sup>14</sup>, as well as the high proportion (1/3<sup>rd</sup>) of children 6 to 9 months that don't receive any complementary foods.

The economic consequences of poor feeding practices are presented as well. For example, the monetary losses due to poor breastfeeding practices equal more than 25% of the budget of the Ministry of Health each year. Deficiencies such as those related to iodine and iron and stunting due to malnutrition, also lead to massive losses in productivity.

The presentation discusses the improvements in nutrition-related indicators targeted for the period 2004-2013 and the resulting economic gains that would ensue. The advocacy presentation continues with a plea for the importance of investing in nutrition and the massive results that could be achieved, as far as lives saved, intellectual development safe-guarded, and economic losses averted. It then ends with recommendations concerning the policies and programmes that could reverse the current situation.



The key outcomes of the workshop included the constitution of a multi-sectoral group of professionals trained in PROFILES scientific basis and in nutrition policy analysis and advocacy, the development of a vibrant advocacy presentation, and the preparation of a longer-term nutrition strategy for policy change including an Action Plan for follow-up. Constraints identified during the evaluation process included lack of financing for continued advocacy, using the presentation, lack of political will and availability on the part of decision-makers, the need to convince several opposition groups and non-nutritionists of the importance of nutrition and a question concerning whether the plan of action would be executed.<sup>15</sup>

Feedback during the case study visit indicated that these concerns expressed by the workshop participants were well founded. There has not been as much use of the PROFILES advocacy presentation and advocacy strategy as wished. An earlier evaluation of the use of PROFILES in West Africa suggested that countries where technical assistance and other follow-up were provided following the workshops were most successful, and that it is important to institutionalize PROFILES at the national level, if it is to have sustained impact.

The PROFILES advocacy tool, “Benin Nutrition Profiles”, is currently under revision and will be disseminated in mid-2009, with a workshop June 1-6. The need for stronger follow-up support and strategies for institutionalizing PROFILES and other advocacy strategies in Benin should be explored.

### ***Implementation of the International Code of Marketing of Breast-milk Substitutes***

A code (Decree) on the regulation of the marketing of breast-milk substitutes and baby foods (*Décret No 97-643 portant règlementation de la commercialisation des substituts du lait maternel et des aliments pour nourrisson*) was passed in 1997. In the early years after its passage, IBFAN provided assistance on monitoring its provisions. The passage of the Decree led to removal of baby photos on infant formula packaging and an absence of formula marketing and donations in health facilities. However, enforcement

<sup>14</sup> A larger number of deaths would be attributable to inadequate breastfeeding if the deaths due to diarrhea had been estimated at 15% (2469 deaths) rather than at 8% (1714 deaths). This higher percentage for deaths due to diarrhea may be more reasonable. (Communication from Dr. H. Stiefel.)

<sup>15</sup> Stiefel et al. op.cit, p. 15.

is very difficult within the informal market economy. A recent report to UNICEF/New York (2007) on the state of the Decree in Benin provided the following observations:

- The Decree is somewhat out of date, as it still recommends exclusive breastfeeding for 4 to 6 months, and thus needs revision. Regulations concerning marketing of foods for young children should also be considered.
- There is no active committee currently overseeing monitoring and enforcement of the Decree. There is a focal person for application of the law in three Ministries (health, food and industry) and none in other Ministries listed in the Decree (economy, education, cooperation, justice and communication).
- There is only a passive system for monitoring, meaning that violations can be reported if observed, but no complaints have been received in the past 5 years. There are no tools and no system for monitoring and no resources designated for monitoring.

Data from the Benin DHS reports for 1996, 2001 and 2006 indicate that use of formula for children under 6 months of age has substantially increased, with rates for children 3-6 months of age at 5% in 1996 and up to 22% in 2006. Bottle-feeding rates for children of this same age group increased from 7% to 12% during the same time period. (See “Results” section for details.) These figures indicate that, while Benin does not have extremely high rates of bottle-feeding and formula use, the rates are increasing, and thus monitoring and enforcement of the Decree would be useful to help reverse this trend. The dangers of giving formula companies free reign can be seen in Gabon, which had formula feeding rates of 48% and bottle feeding rates of 44% for children 4-6 months of age as reported in their 2000 DHS.

A review of the wording of the Decree itself indicates that several changes are needed. As mentioned in the report to UNICEF, the recommended age for exclusive breastfeeding needs to be revised. In addition, clearer guidance needs to be given within the Decree concerning use of breast-milk substitutes for children of HIV positive mothers and for children in emergency situations, and possibly for marketing of foods for young children. Work is currently underway to revise and strengthen the Decree, with the MOH taking the lead. Resources are available from UNICEF/NY and within the region for updating and strengthening Code documents and developing systems for Code monitoring and enforcement. These should include a focus on the departmental level.

### ***The Baby Friendly Hospital Initiative (BFHI)***

The Baby-friendly Hospital Initiative (BFHI) (Initiative des Hôpitaux Amis des Bébés) was launched both internationally and for Benin in 1992. Master trainers and assessors were trained in Bangui. A national committee for coordination of BFHI was established in 1993 and became official in 1999, through a government order. Some good progress was made in Benin in the area of BFHI in the 1990s with training, assessment, and designation of 26 baby-friendly facilities (hospitals and health centers). A pool of around 15 external assessors was developed (with 2 per department). Both IBFAN Benin and the regional IBFAN office for francophone Africa helped with the Initiative. UNICEF originally paid for a BFHI coordinator, but later the MOH took over. Facilities were monitored, to some degree, in the early days. Benin hosted a regional BFHI workshop in Cotonou in 1999. Benin also participated in a regional BFHI assessor training workshop in Gabon in June 2002 and 3 additional facilities were assessed. According to MOH data, maternities in 12 of Benin’s hospitals and 15 of its health centers are currently designated baby-friendly.<sup>16</sup>

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<sup>16</sup> UNICEF’s records indicate that there are 106 hospitals in Benin. There were 588 public maternities in health centers, according to “Annuaire statistiques 2007”, but some of the health centers are now first referral hospitals. Statistics on the number of private maternities are not available. UNICEF and the MOH report that it is not possible to determine what proportion of institutional deliveries take place in baby-friendly facilities.

Currently 78% percent of Benin’s deliveries are institutional and thus adherence to BFHI’s “Ten Steps” is essential to providing good early support for breastfeeding. However, currently little is being done. Informal feedback indicates there was little advocacy to gain decision-makers commitment, that training, assessment and on-going monitoring have not continued and that compliance is slipping in designated facilities. Reassessments of certified hospitals have not taken place either. “Step Ten” continues to be a challenge, with a few support groups organized but many deteriorating or disbanding over time.



During a visit to one of the most recently designated health facilities, the Baby-friendly plaque was seen stashed behind a divider board, giving the impression that baby-friendly status was currently not that important to the facility. Discussions revealed that at least some of the newly arrived staff had not been briefed on the Initiative or given any orientation on the “Ten Steps”.

A formal evaluation of the status of BFHI and the designated facilities in Benin was recommended by the WHO country office, and an evaluation of BFHI is in the current (2009) annual work plan for the MOH and UNICEF.

Recently, there has been a new emphasis at international level on revitalization and national institutionalization of BFHI, in light of the new Global Strategy for IYCF, which continues to emphasize that implementation of the “Ten Steps” is essential for a good early start in breastfeeding. In addition, revised courses and assessment, monitoring and reassessment tools for BFHI have been completed with the support of UNICEF and WHO, and will soon be available in final form. The new WHO/UNICEF guidance emphasizes that it is essential for countries to provide the support needed for BFHI and integrate it within the health system, with plans for continued training, certification and monitoring of maternity facilities, if possible as part of an overall quality assurance programme, so that adherence to the “Ten Steps” will be sustainable over the long term.

***The Minimum Package of Essential Nutrition Actions (Paquet Minimum d’Activités de Nutrition (PMA/Nut)***

Before the introduction of the Promotion of the Minimum Package of Essential Nutrition Actions (Paquet Minimum d’Activités de Nutrition or « PMA/Nut ») in Benin, nutrition activities were scattered across various ministries and there was little integration of nutrition activities within routine health services. PMA/Nut was launched in the Borgou region (one of 6 regions in the country at the time) in 1998, continuing to 2002 with financial and technical support from the USAID-funded BASICS Project. This region was selected because it was one of the most disadvantaged areas in the country, with 35% underweight according to the 1996 DHS – highest in the country. In 2002 PMA/Nut was formally adopted as a national strategy and an integral component of the country’s IMCI programme, although national coverage has not yet been achieved. Currently 42 communes out of 77 (55%) are covered by the full PMA/Nut package. Other communes are covered by part of the package (exclusive breastfeeding, complementary feeding, iron-folate supplementation and nutritional management of the sick child), with no follow-up in these communes. The strategy has received support from USAID, UNICEF, WHO, the World Bank and the Government. UNICEF provided 223,571.08 USD for PMA/Nut from 2004-2008. Currently PMA/Nut receives support from UNICEF and the Government.

The PMA/Nut package contains six key actions:

1. exclusive breastfeeding (EBF) for infants up to about six months of age;
2. complementary feeding (CF), with continued breastfeeding from six to 24 months;

3. vitamin A supplementation;
4. iron and folic acid (IFA) supplementation for pregnant women;
5. iodized salt promotion for the general population; and
6. nutritional assessment and counseling of the sick child.<sup>17</sup>

The objective of the programme was “to deliver a set of proven actions at the health facility as well as the community level and to reinforce key nutrition behaviors through a communications programme to improve the nutritional status of mothers and children”.<sup>18</sup> This new approach gave priority to the groups most at risk, focused on preventative elements, and provided simple and practical actions that could be implemented by health workers and community members to increase coverage. The PMA/Nut programme worked to strengthen the capacity of the health system to carry out these six key components through a cascade-type training model which started in four sub-districts and then expanded to ten more, consolidating the process continually through supervision. As this was taking place a “spillover” effect was noticed, with other regions also starting to use some of the tools. The national government was both informed and involved through formal and informal mechanisms.<sup>19</sup>

The Departmental Directorate for Health (DDS), which serves as the provincial MOH representative, was involved early in the project, in 1997, in joint assessment and planning activities. The PMA/Nut interventions were addressed through a health facilities component, a community component and a multi-media communications component.

- Health system strengthening included training for health workers on the principles of the approach, technical issues, and use of counseling tools, as well as how to manage supplies, adapt the health information systems and supervise staff effectively.<sup>20</sup>
- The community component involved training community volunteers on simple, doable action messages and linking health facilities to communities which enabled the volunteers to support and counsel lactating mothers at the community level and refer them to the health centers when needed. Community members were involved in the design and dissemination of nutritional messages and helped to identify and implement effective strategies for insuring that targeted beneficiaries were reached.
- The communications strategy was elaborated early in programme development. It included a number of creative components including use of traditional theater and mass media activities, such as radio spots and newspapers, to complement the work of health providers and community volunteers.<sup>21</sup> (See the “Mass Media and Promotion” section below for more details.).

The PMA/Nut approach resulted in expansion of routine health services to deliver priority nutrition services. The capacity of health service and community-based workers to provide preventive care related to the six essential actions in a cost-effective, integrated manner improved. Communication expanded to reach many different audiences. As a result, the access of families to critical information increased and infant feeding and other nutrition practices improved.

Results from a number of complementary surveys in the Borgou area indicate that during the period that PMA/Nut was active in the region, increases in exclusive breastfeeding rates were higher than for the country as a whole.

Results from the surveys in the region show exclusive

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<sup>17</sup> BASICS II Country Report, Benin (2004), p. 7.

<sup>18</sup> Ibid., p. 10.

<sup>19</sup> Ibid., p. 13.

<sup>20</sup> The PMA/Nut tools include a training manual for learners (Manuel de l’Apprenant) and for trainers (Manuel de l’Formateur).

<sup>21</sup> From Acharya, “Using “Essential Nutrition Actions (ENA)” to accelerate coverage with nutrition interventions in high mortality settings”, p. 62-65.

breastfeeding rising from 19% in the 1996 DHS to over 60% in the 2002 PROSAF<sup>22</sup> study in selected areas of the Borgou region (see Figure 1 at right<sup>23</sup>) while at the national level it rose from 10% in the 1996 DHS to 38% in the 2001 DHS (see Results section). A review of the DHS figures for 1996, 2001 and 2006 for the “median duration of exclusive breastfeeding” for Borgou/Alibori and then “all Regions” also indicates that the median duration rose faster in the region where PMA/Nut’s activities were focused (from 0.5 to 1.4 to 2.7) than it did in the country as a whole (0.5 to 1.1 to 1.9).<sup>24</sup>

A comparison of household knowledge of key practices in pilot and non-pilot areas showed that knowledge in pilot areas was much higher. Knowledge that early initiation was useful, for example, was 70% in the pilot area versus 20% in the non-pilot area, and that exclusive breastfeeding was recommended was similarly 88% versus 30%. These results helped confirm that the behavioral changes, such as those described for exclusive breastfeeding above, were most likely related to the impact of the programme.<sup>25</sup> Some of the increase in exclusive breastfeeding rates at national level is likely due to the impact of PMA/Nut both in Borgou and in other regions where it was replicated.

Efforts to bring the programme “to scale”, covering all regions of the country as well as to sustain programme approaches once adopted, were quite intense, but led to mixed results for a variety of reasons. (See section on “Sustainability and Scale-up”.)

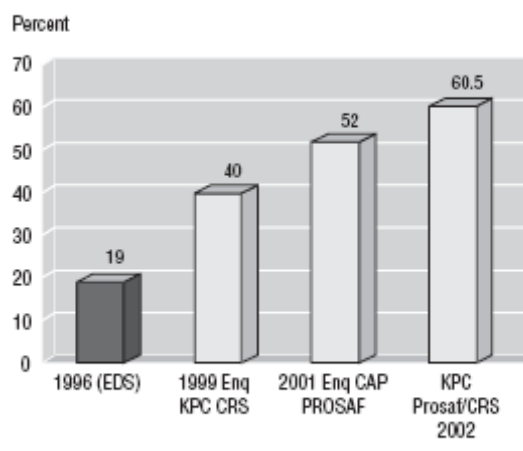
As mentioned earlier, a more integrated approach to “essential practices” is currently being pursued, focusing on “Essential Practices for the Feeding and Nutrition of Women, Infants and Young Children” (*Pratiques Essentielles pour l’Alimentation et la Nutrition de la Femme, du Nourrisson et du Jeune Enfant*), which combines PMA/Nut, maternal nutrition and HIV/AIDS.

### Communication

Information, education and communications (IEC) activities have been a part of health and nutrition strategies in Benin through the years. Group talks on nutrition topics are often given during antenatal care and well-child clinics, as well as during growth-monitoring sessions. Individual counseling takes place both at health and social service facilities as well as during home visits. Production and distribution of posters, airing of radio talks and spots, and television campaigns have been common at various times. The Ministry of Communication and New Technologies has been active in development of messages and transmission of programmes in the national dialects. IBFAN was involved in producing newsletters, posters, articles and radio and TV spots, especially in the 1990s. World Breastfeeding Week has been used as an opportunity for more intense breastfeeding promotion, using a variety of advocacy and IEC approaches, including radio messages in local languages and celebrations organized by mother support groups. While 11 localities celebrated the week in 2007, this increased to 28 localities in 2008. National

**Figure 3**

**Benin—Trends in Exclusive Breastfeeding, Borgou Region, 1996–2002**



Source: BASICS II Self-Assessment Report for Project Year Four (June 15, 2002 - June 14, 2003)

<sup>22</sup> Promotion Intégrée de Sante Familiale, a bilateral project funded by USAID

<sup>23</sup> From “Benin: Introduction of *Paquet Minimum d’Activités de Nutrition* (PMA/NUT as National Strategy, p.2

<sup>24</sup> Comparison made using data generated using the MEASURE DHS “STATCompiler”.

<sup>25</sup> Ibid. p. 15.

reports on the celebrations suggested the need for more involvement of health personnel and facilities, strengthening of mother support groups, and greater media coverage other times of year.<sup>26</sup>

The PMA/Nut programme developed a new model for accelerating the development of IEC messages and materials. The heart of the development process was a multi-purpose workshop in 1998 with three sub-workshops that developed the same content for different communication channels: a) traditional media, b) print material, and c) radio. Community members such as traditional communicators, youth and women's group representatives, health workers, professors and graduate students, journalists, traditional singers, and artists participated in the workshop, resulting in on-the-spot production of a range of well-adapted IEC materials.<sup>27</sup> These materials, which were pre- and post-tested before being mass produced, included:

- About 900 flip charts (“*boites a images*”) for health workers
- 20 radio spots and quiz programmes
- 500 audio cassettes for health facilities, schools, NGOs, community development organizations, taxi drivers, hair dressers, military camps, libraries, political leaders and members of royal courts
- Four dramas for theater groups
- Revised Child Health Cards and Maternal Cards that accommodated the new nutrition actions, with the changes incorporated into the Routine Health/Management Information System for Borgou and Alibori departments

The flip charts (“*Boites a images*”) included two sets, with the first focusing on such topics as early initiation (at home and in the maternity), the importance of feeding with both breasts (see photo at right), the importance of exclusive breastfeeding for six months and refusing water or traditional herbal teas (*tisanes*) (see photo at right)<sup>28</sup>, appropriate foods to feed after six months and avoiding the tradition of forced feeding (*le gavage*), etc. The messages were based on extensive formative research and were thoroughly pre-tested. The graphics are well done and culturally appropriate. Each graphic has clear guidance on the back for counseling on the topic.



Arrangements were made with local “community” radio stations for the full implementation of the IEC programmes at no cost to the project in exchange for benefits such as communications and technical training for radio personnel and/or supplies needed for broadcasting. Similar agreements were made with theater groups, including a traveling youth and woman's troupe that performed throughout the region.

A national integrated nutrition communication plan is being developed (with World Bank support) and will be finalized in 2009. In 2009, UNICEF will continue to support the process to ensure that the IYCF component is well integrated in this communication programme (including the formative research and the development of adequate tools and messages).

<sup>26</sup> Ministère de la Sante, Service Nutrition, Rapport: Célébration de la semaine mondiale de l'allaitement maternel, 2007, 2008.

<sup>27</sup> Ibid. 2004, p. 19.

<sup>28</sup> The Grandmother Project, discussed on page 26, recommends positive ways of teaching grandmothers about optimal IYCF practices and involving them in planning and implementing strategies for change.

## ***IYCF training and education***

In-service training of health providers and community workers and volunteers in the areas of breastfeeding and complementary feeding has been a part of the health and social service systems' mandate for years. In the 1980s breastfeeding was one of the key primary health care strategies and later, in the 1990s, part of child survival programme. The BFHI focused on training of maternity services staff to implement the “Ten Steps”, using the “18-hour course” for maternity services. The “40 hour” Breastfeeding Counseling Course, developed by WHO/Geneva, was available in French for training nurses, midwives and other staff serving as breastfeeding counselors. Initially the 40-hour course was used for training but, during the PMA/Nut era, its use was reduced. Parts of the 40-hour course were used to design the PMA/Nut training modules.

The PMA/Nut programme developed a set of training modules<sup>29</sup> for health workers with the involvement of the Departmental Directorate of Health that focused on the use of the two sets of flip charts for counseling purposes and provided in-depth practical knowledge and skills for each of the topics covered. The training followed the cascade model, starting with training of 16 trainers who, in turn, trained 567 health workers in the initial four sub-departments in 1998-1999. Soon after, the training was extended to the other 10 sub-departments. Currently there are 132 trainers in 10 health zones, out of a total of 34 health zones. Supervisory observations of health worker performance and interviews with the workers themselves indicated that the training influenced them to spend more time on nutrition actions.

The IMCI programme provides training on the “essential nutrition actions” as well. About 30% of the training content is focused on clinical practice and an estimated 835 providers are trained each year.<sup>30</sup> A course focused on “Strategies to reinforce actions in favor of early childhood” (“petit enfance”) was developed by UNICEF for the EDUCOM project. The course can be used by teachers, health agents, community agents, religious leaders and community members. Two key themes are “Breastfeeding” and “The Nutrition and Growth of the Infant”.

Freedom from Hunger's (FFH) “Credit with Education” programme integrates micro credit with health and nutrition education and has worked with credit partners such as FECECAM and PADME<sup>31</sup> to launch this programme in Benin. FECECAM, which started in 2000, has reached more than 20,000 women in rural areas across the Zou, Collines, Alibori and Couffo regions. PADME, launched in 2007, has provided service to about 4,500 women in the Plateau region. Both organizations would like to expand in the north of the country, where there is a lot of need for assistance. FFH has two courses in French that focus on IYCF topics: 1) “Improving Breastfeeding – Everyone Can Contribute” (*Amélioration de l'allaitement maternel – Chacun peut contribuer*) and 2) “Infant and Young Child Feeding: Helping Young Children to Eat and Grow Well” (*Alimentation du nourrisson et de l'enfant: Aider les jeunes enfants à bien manger et grandir*). These courses are very



<sup>29</sup> “Manuel de l'Apprenant” and “Manuel du Formateur”, PMA/Nut, Ministry of Public Health, Directorate of Family Health, Nutrition service.

<sup>30</sup> L'ANJE, Outil d'évaluation nationale des pratiques, des politiques et des programmes, 2006, p. 53.

<sup>31</sup> Fédération des caisses d'épargne et de crédit agricole mutuel (FECECAM) and Projet d'appui au développement des micro-entreprises (PADME)

practical, focusing on actions women, families and communities can take to improve IYCF. These courses and others are provided by the field agents (“animatrices”) who are trained to provide a package of micro-credit and educational services to clients.

WHO has played a leading role in encouraging the launching of the recently published “Infant and Young Child Feeding Counselling: An Integrated Course”. This is a five day course, available in French, that integrates the key content from three courses, also available from WHO, on breastfeeding, HIV and infant feeding and complementary feeding counseling. WHO supported training for course coordinators that took place in Niger and Mali and then the training of 12 trainers in Benin in November 2007. The next step will be for the Ministry to begin using these trainers for further training, with possible support from WHO and other donors.

Breastfeeding and young child feeding is addressed in many pre-service education programmes such as those in schools of medicine, nursing and midwifery, but usually in a very rudimentary fashion, focusing mainly on theoretical knowledge, without much practical guidance for dealing with breastfeeding management issues<sup>32</sup>. Professors are usually responsible for their own course content. There have not been any systematic efforts in these schools to strengthen the curriculum related to these subjects or provide needed audiovisual or demonstration materials, although there are now many course documents (such as the BFHI, PMA/Nut and IMCI training materials and the Integrated Course for IYCF and related WHO Courses) that could be used to fortify course content. Professors have not, thus far, received training on how to strengthen the IYCF content of their courses and clinical practice sessions. The Regional Institute for Public Health at Ouidah, the regional school of WHO, on the other hand, did give students practical training on PMA/Nut for several years.

### ***Community-based promotion and support***

Community-level nutrition promotion and support activities have been underway for more than 15 years. As early as the 1980s Italian aid collaborated with the Directorate of Food and Applied Nutrition (DANA) to promote breastfeeding and appropriate complementary feeding, produce foods for babies and young children, and promote good nutrition in the schools. Catholic Relief Services, Plan Benin, Care International and UNICEF also collaborated with DANA on nutrition education at the level of the town (*commune*) using women leaders in the 1980s and at the level of the urban district (*arrondissement*) beginning in 1995. Some work at village level began in 2000, but not at a large scale. In many cases the women identified for voluntary community work served as “mediators”, acting as the formal link between the community and health facilities. Sometimes women’s groups (*groupements féminins*) were encouraged to engage in income-generating activities to gain the resources needed to put into practice what they have learned. Through these group activities, communities began to take charge of their own development.

The World Bank-supported Community Food Security Project (*Projet d’Intervention Locales pour la Sécurité Alimentaire - PILSA*), which was implemented from 1996 to 2000, had a major community nutrition component. It was implemented by NGOs, with direction from MAEP, using a strategy based on the mobilization of Community Nutrition Workers for monthly nutrition activities, including monitoring of pregnant and lactating women, growth monitoring and promotion, and the establishment of village nutrition committees. Its services covered about 10% of the population.<sup>33</sup>

The Community IMCI programme (PCIME-C) includes a focus on exclusive breastfeeding, adequate complementary feeding, feeding of sick children, provision of iron and folic acid to pregnant women,

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<sup>32</sup> Information was not available concerning whether practical guidance on IYCF is given in residency or other pre-work practice programmes. This needs further exploration.

<sup>33</sup> The Director of DANA interviewed is no longer in the position and information on possible evaluations of this Project and others supported through DANA is not available. The PILSA Project has not been continued.

consumption of iodized salt, and care for sick children at home. The programme covers 10 out of 34 health zones and reaches 29% of the population, with support from MOH, UNICEF and various NGOs.

The Community Programme for Health and Nutrition of the Mother and Child (*Programme Communautaire de Sante et Nutrition de la Mère et de l'Enfant*), implemented by CRS in collaboration with DANA and the social promotion centres, focuses on exclusive breastfeeding, complementary feeding, nutritional rehabilitation at home, and consumption of iodized salt.

The BFHI also includes a “community component”, with “Step 10” encouraging health facilities with maternity services to foster “mother support groups” for breastfeeding. Many of these groups have become inactive over the years. In early 2007, the MOH worked to reactivate 79 groups<sup>34</sup>, and this process is on-going. The “mother support group” and peer counseling approaches have been used within the PMA/Nut community component as well, both by the BASICS Project and follow-on projects such as PROSAF, with the assistance of CRS, and Swiss and German aid agencies. Training in the use of printed counseling materials, such as the flip charts (*boites a images*) is provided.

The nutrition demonstration foyers (centers) (HEARTH) (*Foyer d'Apprentissage et de Réhabilitation Nutritionnel* or FARN) focus on the identification of « model mothers » or mothers as « positive deviants » who have been able to nurture their children successfully in disadvantaged circumstances. These mothers help others with malnourished children to engage in behaviors that prevent malnutrition as well as identify and prepare healthy local foods that children will eat, using their kitchens as “hearths” for two weeks during which the participant mothers begin the rehabilitation process. The volunteer mothers then follow up with home visits and, finally, the children are re-integrated into the growth monitoring programme.<sup>35</sup>

Strategies for community outreach, including organization of mother support groups, use of peer counselors (sometimes the mothers from the support groups) for home visits, and organization of nutrition rehabilitation activities at community level have varied in their effectiveness. Challenges include how to motivate volunteer workers when there are no fees or permanent incentives, how to maintain regular and efficient supervision, and how to sustain these workers and groups over time, with different partners and projects striving to utilize them, often with uncoordinated and sometimes conflicting approaches. Key lessons concerning the most effective approaches are described in the “Lessons Learned” section presented before the “Recommendations”.

### ***Maternity legislation and mother baby friendly workplaces***

As mentioned earlier, Benin has passed regulations concerning maternity leave (14 weeks, with full pay) and breastfeeding breaks (one half hour in the morning and again in the afternoon). Women who are self employed (such as market women and artisans) traditionally have taken leaves of 3 months from their work after birth and bring their babies with them, when possible, to their places of work. However, women employed in the informal or private sectors do not have the advantage of the application of maternity leave regulations. In addition, there has been little attempt to provide “crèches” or child-care facilities close to places of work, where women can leave their children and breastfeed them during breaks. The only such facility was at UNICEF, during a time when staff members were breastfeeding and had need of this service. Similarly, there have been no efforts to organize “breastfeeding rooms” in places of employment where mothers can either breastfeed their infants or express and store milk during working hours and little endeavor to promote the use of expressed breast milk. Challenges include the need to sensitize employees to the need for these services and decision-makers to their importance.

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<sup>34</sup> Information is not available concerning how many BFHI facilities these groups were attached to.

<sup>35</sup> Report on Positive Deviance/Hearth Workshop in Benin, p. 1. Information is not available on the scale of this programme or whether it is continuing.

### ***Infant feeding for children in difficult circumstances***

The Government of Benin has two national commissions in place related to emergencies, one in charge of refugees and the other for civil protection during disasters and catastrophes.

A study of the Togolese refugee camps in Agome and Come made it possible to identify malnourished children and assure that they received the health and nutritional care needed. The Departmental Directorate of Health for Mono/Couffo helped with monitoring the Togolese refugee situation and found that approximately 10% of children under 5 years of age in the camps were malnourished. UNICEF provided support for water, sanitation and health in the camps, and the PMA/Nut programme was implemented there. The Ministry of Health currently focuses on malnutrition in disadvantaged areas (*Projet de lutte contre la malnutrition dans les zones déshéritées*) through a national programme.

Much more remains to be done, however, to ensure appropriate infant and young child feeding in emergencies such as famine, floods, fires, and displacements due to war and other catastrophes. Although guidance is available at international level on this topic, it has not yet been made widely available in Benin. The Milk Code (Decree No. 97-643) does not give clear directives concerning how possible donations of breast-milk substitutes should be handled in emergencies. The commissions mentioned earlier, which could help ensure that needed guidelines are disseminated, are not very active.

In addition to the emergencies described above, the HIV/AIDS pandemic has provided challenges for feeding of infants and young children. As mentioned earlier, the prevalence of HIV among adults is estimated to be 1.8% currently, but has been slowly on the rise. To keep the epidemic under control, the Government, with support from UNICEF, UNAIDS, and other partners, has worked to put in place a number of initiatives for HIV/AIDS prevention and control. Thanks to the Multisectoral Project for the Fight against HIV/AIDS, 68% of all villages in Benin have received multi-faceted support for HIV/AIDS prevention. Benin, with encouragement from WHO and UNICEF, recommended exclusive breastfeeding for 6 months for all mothers, including those with HIV, except if replacement feeding was AFASS<sup>36</sup>, even before this was recommended internationally. Work on the prevention of mother-to-child transmission (PMTCT) started in 2000 with 7% of maternities providing PMTCT services in 2004 and 48% providing these services as of 2008<sup>37</sup>. PMTCT is already an integral component of standard practices in those services, with 9 out of 10 women accepting voluntary testing. The “Guide for the management of children exposed to and infected by HIV/AIDS”, produced by the Ministry of Health with support from UN/AIDS, has a detailed section on counseling HIV positive women on infant feeding and WHO has useful job aides on this topic.

### **3.5 Sustainability and scale-up**

Sustainability has been one of the most difficult challenges faced by the breastfeeding and IYCF programmes in Benin, as can be seen in the programme descriptions above. While the BFHI made substantial progress in the 1990s, organizers and reviewers alike admitted that the Initiative’s key weakness was lack of an effective scheme for institutionalization and sustainability. UNICEF, at global level, encouraged governments to implement the Initiative, with support from the UNICEF Country Offices and a focus on “baby-friendly” training and assessment, while neglecting to press sufficiently for national ownership and financing. Strong national support is needed, with the programme integrated into the national health system and mechanisms in place for keeping maternity staff up to date and monitoring on-going adherence to the “Ten Steps”, if possible including BFHI criteria as part of quality assurance schemes.

In Benin, the Initiative was active in training, assessment, and initial designation of baby-friendly facilities through the late 1990s, but neglected to set up viable systems for refresher training or for on-

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<sup>36</sup> Acceptable, feasible, affordable, sustainable and safe.

<sup>37</sup> UNICEF annual report, 2008. Statistics were not available concerning whether PMTCT services are provided in health centers providing antenatal care.

going monitoring or reassessment or to ensure that it was properly institutionalized and became part of the standard operating and accreditation procedures for hospitals . UNICEF-Benin discontinued any support for BFHI after 1998 and related activities greatly decreased. Currently there is insufficient staff within the MOH’s nutrition section to fully reactivate and sustain BFHI (and fully implement other IYCF programmes), although responsibility for the Initiative is lodged within this section. UNICEF will be supporting an evaluation of BFHI and lessons learned by the DSF in 2009, then determining in collaboration with the MOH and other partners what the next steps should be. This evaluation should help determine why the Government did not maintain support for BFHI in recent years. There will be a strong emphasis on institutionalization in any plans developed.

The PMA/Nut Project staff worked the most strategically to foster replication and scale-up of adoption of its programme. The Project, first initiated in Borgou in 1998, worked actively from the beginning to involve decision-makers, both at the departmental level and national level, in planning and programming, so as to gain commitment. The PMA/Nut approaches began to be introduced informally to other departments as personnel who had worked in Borgou transferred during routine turnover with the Ministry of Health. Formally, after the success of the Borgou experience was recognized, the MOH decided to expand the approach to other departments. With financial resources from the World Bank, a national workshop was held in 2001 for health officers from five other regions to familiarize them with the PMA/Nut approach and tools. Action plans developed during this workshop facilitated implementation of PMA/Nut in their respective districts. MOH interest and commitment to expand the programme was facilitated by the involvement of MOH central staff in various stages of development of the approach, including operations research, training and implementation.<sup>38</sup> Success in scale-up of the programme was not fully achieved while USAID was still supporting it, due to several factors, including lack of sufficient personnel and technical and financial resources for successful expansion, need for a simpler “package”, failure to continue to fully involve decision-makers at departmental level, and a change in personnel in decision-making positions within the MOH and USAID leading to a change in focus. A couple more years of support would have enabled the PMA/Nut staff to work closely with national and department officials to more fully institutionalize the programme. UNICEF and the Government of Benin are continuing to focus on “essential practices”, with PMA/Nut now integrated into an “Essential Practices for Food and Nutrition of the Mother and Young Child” programme, which combines PMA/Nut, maternal nutrition and HIV/AIDS, and is in the process of being implemented nationally.

Generally, a number of challenges have resulted in slow progress in “going to scale” including:

- Lack of coordination in the nutrition field, with nutrition and IYCF activities scattered across ministries and lack of clarity concerning the duties of various levels in a decentralized system.
- Inadequate collaboration between various partners and donors.
- A tendency to continue to plan and implement vertical programmes rather than pursue a more cost-effective integrated approach with clear plans for scale-up.
- Lack of sufficient human and financial resources to expand successful initiatives to achieve national coverage in a system where nutrition is not yet at the forefront of the development agenda.<sup>39</sup>

### **3.6 UNICEF’s role and resources**

#### ***UNICEF’s role***

UNICEF-Benin has provided support over the years on a wide range of initiatives focused on the needs of children. Its work is focused in three sectors, survival, education and protection. Its nutrition and IYCF

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<sup>38</sup> BASICS Project final report, 2004, pp. 10-11.

<sup>39</sup> Some points adapted from presentation by Representative. Diallo on *Experiences with improving breastfeeding rates nationwide and factors for success in Benin*, UNICEF New York, November 2008.

support has been implemented as part of its “survival” portfolio. The earlier section on “IYCF Strategies and Plans” describes in detail UNICEF’s contribution to IYCF. UNICEF develops its Country Programmes in close collaboration with the Government and then works to support effective approaches geared to bringing the country closer to meeting the Millennium Development Goals. In the area of IYCF, it has assisted with developing a national Code (Decree) on the Marketing of Breast-milk Substitutes, launching and implementation of the BFHI, replicating and scaling up the PMA/Nut approach, supporting other approaches to control micro-nutrient deficiencies, and strengthening community outreach and the PMTCT component of HIV/AIDS programmes, as well as other initiatives related to complementary feeding and malnutrition.

Focus on breastfeeding promotion as a programming area waned in the early 2000’s, but with the new emphasis placed on IYCF within the Global Strategy, UNICEF-Benin has encouraged the Government to devise strategies and a plan to reach the identified targets. UNICEF assists by serving as an advocate for effective IYCF programming and encouraging various partners and donor agencies to work in a coordinated way to develop a more integrated approach.

**Next steps for IYCF programming in Benin.** UNICEF has identified important “next steps” that it plans to focus on to strengthen IYCF programming, in collaboration with the Government and other key partners. These include:

- Providing technical support to the development of standards and policies for nutrition and IYCF;
- Strengthening strategic partnerships and coordination for nutrition and IYCF (including with the World Bank, the European Union, and universities);
- Ensuring a comprehensive approach to infant and young child feeding practices (continuum of care: maternal, breastfeeding, complementary feeding);
- Advocating for the inclusion of nutrition in the IHP Plus/<sup>40</sup> health framework and initiative (such as the Catalytic Initiative) as well as for fiscal space and resource allocation for nutrition and IYCF (update Nutrition Profiles);
- Focusing on national capacity development (gap analysis, mapping of capacities and prioritized actions with an interagency approach);
- Strengthening community-based approaches for nutrition (communication for development component with formative research);
- Supporting the development of national conceptual frameworks to address chronic, moderate and severe malnutrition with a strong IYCF component (i.e. national multisectorial food and nutrition programme).

**Key IYCF activities for 2009.** Key IYCF activities that UNICEF is encouraging the Government to undertake in 2009, with UNICEF and other donor support, include:

- Validation and dissemination of the comprehensive IYCF strategy and Plan of action;
- Capacity building on IYCF (roll-out of a training strategy);
- “Who What Where” mapping of nutrition partners and partnership with local NGOs;
- Validation of the updated version of the Code (Decree) on the Marketing of Breast-milk Substitutes and monitoring plan with adequate resources;
- Creation of an IYCF /nutrition working group/coordination system;
- Reactivation of the BFHI (at least an evaluation/lessons learned with IBFAN support)
- Development of a communication for development strategy with a strong IYCF component (implementation in late 2009/2010);
- Arrangement of an institutional contract with the university (incl. support in IYCF/ CF);
- Updating of the nutrition profiles (mid-2009) and high level advocacy.<sup>41</sup>

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<sup>40</sup> International Health Partnership and Related Initiatives

**Human rights-based programming (HRBAP) and gender mainstreaming.** These areas have been important “cross-cutting issues” in United Nations and UNICEF programming in Benin. The Common Country Assessment (CCA) and United Nations Development Assistance Framework (UNDAF) use rights-based approaches. The CCA included an analysis, for each Millennium Development Goal, of human rights that were not yet respected, rights-holders and duty-bearers, and their capacity to claim their rights or to meet their obligations. This analysis helped form the basis for the outcomes identified in the UNDAF, which, together with the results of the 2006 Mid-term Review and the UNICEF medium-term strategic plan (MTSP) 2006-2009, constituted the reference points for the development of UNICEF’s Country Programme document.<sup>42</sup>

Recent UNICEF annual reports suggest that discrimination related to women remains a problem, hampering equitable development. For example, the percentage of salaried women in the public sector was only 26.8% in 2002, just slightly up from 25.4% in 1992, and the percentage of women in government actually decreased from 14% in 1990 to 10.5% in 2001. Out of 1199 members of communal councils, only 3.2% were women.<sup>43</sup>

UNICEF has tried to address this issue in the design of a number of its programmes. Promotion of equality of the sexes and independence for women is stressed in programmes such as micro-enterprise projects for women, women’s groups, and promotion of innovations in the educational sector. Work has been undertaken to increase the presence of women on community management and surveillance committees as well. In the area of IYCF programming, work to strengthen mother support groups has sought to empower women as “duty bearers” in providing the best sustenance for their children. In some cases income generating activities have been included to give women added resources to support their families. HIV/AIDS programmes have sought to address disparity between the HIV prevalence rates among men and women, with women burdened with rates almost twice as high men’s and linked to their lack of decision-making power. PMTCT programmes are beginning to provide the support HIV positive women need to make informed feeding choices. However, more could be done to systematically analyze how issues related to human rights and gender equity could be more fully addressed as IYCF programming continues.

#### *UNICEF’s and other partners’ expenditures*

**UNICEF-Benin’s** investment in nutrition over the last 10 years has included:

- 1997: 17,300 USD (including 3,400 for BFHI, and 13,500 for Vitamin A and iodine projects)
- 1998: 115,000 USD (including 15,000 for BFHI, 96,000 for Vitamin A and iodine projects, and 4,400 for malnutrition projects)
- 1999-2003: 450,000 USD (for control of micronutrients deficiencies)
- 2004-2008: 2,278,537 USD (out of which 223,571 USD were provided for PMA/Nut, including training, supervision, routine supplementation of vitamin A and control of iodine deficiency disorders).

As these figures suggest, funding for BFHI was discontinued in 1999. Funding related to IYCF-related activities did not start again until 2005, when UNICEF began to support the scale-up of PMA/Nut (ENA) activities, which included promotion of improved breastfeeding and complementary feeding practices.

For 2009 – 2013, UNICEF-Benin has budgeted 24,350,000 USD for Child Survival and Development (RR: 6,350,000 USD, OR: 18,000,000 USD), with a quarter of this total allocated for nutrition. Resource mobilization and leveraging is planned for the nutrition sector as well. The 2009 UNICEF nutrition budget (including direction/indirect IYCF activities) is around 1,500,000 USD.

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<sup>41</sup> The information on “next steps for IYCF programming in Benin” and “key IYCF activities for 2009” was provided by the UNICEF Country Office.

<sup>42</sup> Draft country programme document, Republic of Benin, UNICEF, 2008 (E/ICEF/2008/P/L.4), p. 4.

<sup>43</sup> UNICEF Annual Report, Benin, 2004, p. 4.

**BASICS II** Benin Programme Expenditures in the Borgou Region for PMA/Nut totaled \$1,036,845 (1998 to 2003).

The government's allocation for health and education has increased by an average of 17% between 2002 and 2006. In 2007 the Ministry of Health's budget was close to 60 billion FCFA (approximately 119 million USD at current exchange rates), up from 39 billion in 2002.<sup>44</sup> No details were available concerning government expenditures for nutrition or IYCF through the years.

## 4. Discussion

### 4.1 Factors contributing to results

#### *Programmatic factors*

A number of programmatic factors are likely to have had a strong affect on IYCF-related indicators. As discussed earlier, the rates of exclusive breastfeeding rose quite precipitously from 1996 to 2001 (from 10.1% to 37.9% for children < 6 months of age) and then continued to rise to 43.7% in 2006.

Programmatic inputs that may have contributed to this improvement and the related rise in early initiation rates include:

- Concentration on the “Ten Steps” with the 26 hospitals and maternities designated baby-friendly between 1993-1996/7 and 3 more in the 2000s.
- The regional political context in the mid-1090s due to ECOWAS<sup>45</sup>, that helped to catalyze national development efforts, including those in nutrition
- A strong emphasis on promotion of improved IYCF and nutrition practices in the Borgou department during the BASICS Project's support for PMA/Nut between 1997 – 2003 and, more widely, through PMA/Nut activities in other departments through a partial scale-up from the early 2000s on.
- The development of the DANA nationwide nutrition network, focused on promoting optimal complementary feeding and prevention and treatment of malnutrition.
- Promotion of exclusive breastfeeding as a strategy for preventing diarrhea within the national diarrheal disease programme by decreasing the exposure of infants less than 6 months of age to contaminated water, herbal teas and foods.
- IYCF activities of other programmes and projects, including the passage of the Milk Code (Decree), communication of key IYCF-related messages through other nutrition programmes and projects and yearly World Breastfeeding Week celebrations.
- Good strategies at the global level and on the part of partners, encouraging country action.

While there has been an emphasis on rehabilitation of malnourished children, there has not been a similar emphasis on complementary feeding practices and data show that progress in this area has been much slower. For example, 1/3<sup>rd</sup> of infants from 6 to 9 months of age still do not receive complementary foods. Only 61% of children 6-23 months of age consume foods from at least 3 or 4 food groups, and only 49% eat at least a minimum number of times per day (2006 DHS). In addition, data on stunting, wasting, underweight in Benin (see Table 2 above) show that progress in tackling these problems has been much slower.

Programmatic factors that are likely to have had negative effects on IYCF indicators include many problems that were mentioned earlier, and continue to be a challenge:

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<sup>44</sup> Republic of Benin, Ministry of Justice, *A World Fit for Children, National Report – Benin, 2006*, p. 6.

<sup>45</sup> Economic Community of West African States

- The lack of emphasis on nutrition as a key factor affecting development, with fewer resources focused on it, as a result
- Lack of staff well trained in nutrition and rapid turnover of personnel, with poor orientation of replacement staff on key IYCF-related skills
- Lack of institutionalization and ownership of the BFHI within the national health system, leading to poor sustainability and low coverage
- Lack of strong and systematic follow-up and supervision after training of cadres at various levels
- Lack of sustained emphasis on key nutrition-related strategies and challenges in “going to scale” due to an uncoordinated approach among various Ministries and donor organizations, and the challenges of working within a decentralized system.

### ***Factors external to the programme***

A number of external factors also continue to have a strong effect on results. As mentioned earlier, negative factors include cultural beliefs favoring early introduction of water, herbal teas and other liquids and foods; poor hygienic and sanitary conditions; women increasingly joining the labor force while workplaces supportive of breastfeeding are still not the norm; and endemic corruption, low income, literacy and educational levels and other socio-economic factors, including the recent precipitous rise in food prices, among others. The fact that Benin is a relatively small country may make it easier to achieve further results, when effective strategies are put in place.

## **4.2 Lessons Learned**

### ***Development of an integrated nutrition programme***

Often, in the past, projects and programmes have been vertical in nature, with lack of coordination among them. BFHI, for example, was a vertical programme. Some useful attempts at integration, such as PMI/Nut, have been launched in selected zones, with limited success in “going to scale”.

One key problem in Benin, as elsewhere, has been the frequent change in strategies and initiatives through the years, with donors changing emphasis and project support, often with not enough regard for retaining what has worked well. Currently, however, a good climate exists for thoughtful development of a strong integrated nutrition programme. UNICEF and WHO are stressing the importance of a more integrated approach both at headquarters and country level. In addition, the efforts of Dr. Hessou and the CORE Group to organize an initiative focused on placing nutrition squarely at the center of the development process, with support from the World Bank, are encouraging. Once the High Commission for Nutrition and Multi-sectoral Programme for Food and Nutrition are in place, various partners will be encouraged to participate in the development and implementation of the Programme through provision of both technical and financial support.

The Directorate of Family Health is in the process of preparing a draft IYCF action plan. Review shows that while it includes a number of the new key elements proposed in the Global Strategy for a solid national IYCF programme, enough consideration has not yet been given to how to further combine the proposed actions with other aspects of nutrition, to achieve a more integrated programme.

### ***Strengthening advocacy, protection and support for IYCF at policy level***

Good work has been done in the past on development and use of advocacy tools that could be helpful for policy level advocacy for an integrated nutrition programme. For example:

- The PROFILES initiative developed a well designed advocacy tool, described earlier.
- WHO developed and field-tested a Short Course for Administrators and Policy Makers for use within the BFHI programme to convince decision-makers of the Initiative’s importance and gain their commitment. It has very recently been updated and is included as the “Decision-makers Course” in the revised BFHI package.

- The Lancet series on maternal and child under nutrition (2008) and articles on the impact of various child survival strategies in earlier series could be quite helpful in advocacy efforts as well.
- The “Marginal Budgeting for Bottlenecks” budgeting tool developed by UNICEF, WHO, the World Bank and UNFPA could be used to feature the benefits from appropriate nutrition programming and investment.

### ***Strengthening implementation and enforcement of the International Code***

Benin has had a Milk Code (Decree) since 1997 but little has been done recently in the way of systematic monitoring and nothing in the way of enforcement. There appears to be no active committee for Code monitoring at national level. Data from the DHS indicate that bottle and formula feeding rates are on the rise for some age groups. Experiences from other countries indicate that a strong Code and sustained monitoring and enforcement are important to keep negative marketing practices in check.

### ***Revitalization and institutionalization of the BFHI***

Benin has experienced a “BFHI trajectory” similar to many other countries with the level of activity decreasing due to lack of institutionalization as UNICEF and WHO went on to emphasize and support other initiatives. On the other hand, the need for baby-friendly care in maternity services in Benin is great, as approximately 78% of all deliveries take place in health facilities. Thus it would be useful to take advantage of the mandate for revitalization of BFHI, as expressed in the Global Strategy for IYCF, and the availability of the newly revised BFHI courses and assessment, monitoring and reassessment tools. It is important the Benin take national ownership of the Initiative and explore ways to more successfully institutionalize implementation of the “Ten Steps” within all maternity services, exploring possibilities, for example, for including BFHI within accreditation criteria. Without integration of BFHI into the health system, with adequate monitoring, experience has shown that compliance will not be sustained.

Thus far BFHI has not included a “home delivery” component which could provide training for traditional birth attendants and others providing support for mothers giving birth at home. These mothers, 22% of those giving birth, are likely to be from some of the poorest parts of the population, and thus in great need of breastfeeding counseling and support for early initiation.

### ***Other opportunities for supporting IYCF within the health system***

The experience of PMA/Nut has shown that breastfeeding and complementary feeding support can be successfully integrated into the counseling and support provided for pregnant women and mothers at other contact points. Support may be increased, for example, during well-baby visits, sick child consultations, and immunization and growth monitoring sessions, both in hospitals and health centers at various levels.

### ***Possible programme strategies at community level***

Benin’s experiences with community-based breastfeeding and nutrition programming at community level could be considered when designing the future IYCF programme and the overall integrated nutrition strategy. For example:

- The PMA/Nut programme, with support from the BASICS Project, developed an effective set of strategies and tools to use when working with key decision-makers and with training and monitoring staff as they implement effective IEC approaches and apply the PMA/Nut package at community level through home visits, although the programme was somewhat too complex for general implementation. The PMA/Nut IEC and media strategies are very creative but experience has shown that if the programme is to be successfully “scaled-up” a simpler communications strategy must be designed, using only the most cost-effective channels.
- Several community outreach programmes have used the effective “trials of improved practices” (TIPs) or “negotiation” strategy as part of their IYCF peer counseling approach. This approach involves at least three visits to households with pregnant women, new mothers, or families with

malnourished children: 1) a visit to review the situation and current feeding practices, 2) a visit to discuss and negotiate with the mother (and her family) to try one or more improved infant feeding practices, and 3) a visit to assess what has been tried and what more needs to be done to achieve success.

- In some local settings, the women who become “peer counselors” agree to first try the improved practices themselves. In Adja-Ouere, for example, the women from the women’s groups (*groupement feminine*) with new babies agreed to try exclusive breastfeeding. This personal experience and the very positive results it brought greatly strengthened their ability to work successfully as “peer counselors” to advocate and support improved practices. (The photo at the right shows some of these women with their babies, now a bit older and growing well.)
- Some programmes have used mother support groups that are already functioning at community level in the programme. For example, women’s groups and credit associations with “solidarity groups” are in place in some communities. Religious and various traditional organizations have community “mother groups” or other community groups that may be willing to be involved. It is cost-effective to involve existing groups in IYCF activities, if they do not become over-loaded, rather than to “start from scratch” with new ones.
- Mother support groups focusing on IYCF may be fostered by the Health Centers (Centres de Santé). It is useful to consider supporting groups through the Social Promotion Centers as well, as they already have a strong mandate to do community outreach. Incentives to encourage sustained participation in support groups and/or as peer counselors have included providing training and recognition, holding celebrations, providing needed support for food and transportation or bicycles for transport, making sure that the women themselves manage their group and decide on their own priorities, including income generating or micro-enterprise activities, and engaging the women in work that shows satisfying results appreciated by the community.
- There are tools already available for training peer counselors and community members. These include strategies and tools for organization of micro-credit programmes that can provide mothers with the food and other resources they need to successfully care for their children such as the well-designed set of simple training modules on IYCF and business for women in credit associations or other support groups developed by the *Freedom from Hunger* organization.
- The experiences with using the “model mother” at the center of the nutrition demonstration foyers (Hearth) (*Foyer d’Apprentissage et de Réhabilitation Nutritionnel or FARN*) have been quite successful, as the model mother provides a good example of what is possible and gives mothers of malnourished children the confidence that they can succeed in feeding their children with what they have.
- The culturally sensitive strategy for “behavior change” being employed by “The Grandmother Project” in Senegal and elsewhere in West Africa has had impressive results. This Project’s approach is based on grandmothers’ culturally-designated role as advisors and supervisors of younger women and children, believing that community programmes should first acknowledge the role and experience of senior women and, secondly, explicitly involve them as partners and resource persons in all programmes dealing with their areas of expertise – including health and nutrition.<sup>46</sup> The Project is



<sup>46</sup> The Grandmother Project, Strategic Framework 2008-2012, p. 6.

developing very useful tools for designing, implementing and evaluating grandmother-inclusive strategies<sup>47</sup> that could be used in Benin to help strengthen the IYCF approach at community level. Studies have shown that grandmother inclusion contributes to increased programme results and strengthens the positive role that grandmothers can play as development agents.<sup>48</sup>

Good practices and lessons learned need to be more carefully documented and made available, as planning for a more comprehensive and integrated approach continues.

**Strategies for going to scale.** Experience within the PMA/Nut programme, which worked to involve both local and national decision-makers from the beginning, showed that the Government's involvement from the start and at each step of the scaling up process is crucial. The involvement of the community as the entry point in the process and as a partner in "problem-solving" along the way is critical as well. Coordination among key partners, with clear priorities and adequate human, technical and financial resources committed over the long term is essential if national coverage for IYCF and other key nutrition programming is to be achieved.

## 5. Recommendations

### Developing an integrated nutrition programme

- Benin is at a critical juncture, with an important opportunity to develop and implement a truly integrated national nutrition programme with a strong IYCF component. With the current food crisis and high levels of malnutrition the need for action is great. As mentioned earlier, the Ministry of Health is in the process of drafting an IYCF Action Plan for 2008 – 2013 and, at the same time, a High Council for Nutrition is being established and a national food and nutrition programme is being drafted, with support from the World Bank, with the "National Nutrition Programme based on Results" validated in May 2009. The Ministry of Health, other key ministries, UNICEF and other key partners should work closely so that the process of finalizing both the IYCF Action Plan and the National Nutrition Programme are well coordinated as key aspects of a strong, integrated and cost-effective nutrition programme.
- As the draft IYCF strategy and Action Plan is being finalized, care should be taken that it continues to address the key aspects of the Global Strategy for IYCF, while combining the proposed actions with other aspects of nutrition, in coordination with the National Nutrition Programme. The Action Plan should integrate community-based approaches and aim to reach all areas of the country. Further thought needs to be given to the design of a system for monitoring, and strategies for sustainability, with the human, technical and financial resources at a reasonable level.
- In addition, care should be taken as the breastfeeding policy is being updated that it is fully broadened to an "IYCF" policy, covering all key elements stressed in the Global Strategy, including IYCF in difficult circumstances such as HIV and emergencies.

### Programme advocacy and development

Possible steps in IYCF and nutrition programme advocacy and development to consider include:

- Forming a key working group that will guide the finalization of an updated IYCF policy in line with the latest international recommendations and the development of an integrated IYCF strategy. This should include representation from key Ministries, UNICEF, WHO, the World Bank, NGOs, and bilateral aid programmes that could lend support. It might be formed under the "umbrella" of the

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<sup>47</sup> The tools include strategies and technical assistance for designing workshops and seminars, training grandmother groups, designing curriculum materials, and evaluating results in English, French and other languages.

<sup>48</sup> Aubel, J. et al. Senegalese grandmothers promote improved maternal and child nutrition practices: the guardians of tradition are not averse to change. *Social Science & Medicine* 59(2004); 945-959.

“High Council Decree” mentioned earlier. UNICEF, along with other partners, could provide the resources needed for sustained coordination.

- Reviewing the IYCF situation in Benin. This could include an up-to-date assessment of what has worked, challenges, useful “lessons learned”, materials and tools available for adaptation and use in an integrated programme, and key human, technical and financial resources that can be tapped. The results from the earlier “situational analysis and review of IYCF “undertaken by DSF, with WHO support, in June of 2006 as well as the information in this case study could be considered when deciding if additional review is needed. Also, there is currently little information available on the various aspects of complementary feeding, which still is very problematic in Benin. Further research will definitely be needed on this aspect of IYCF to fill in the gaps for better programming.
- Developing an advocacy strategy to raise the awareness of the government of the essential contribution that IYCF and other integrated nutrition strategies could make to decreasing infant and young child mortality, lessening malnutrition and morbidity, and fostering socio-economic development. Advocacy strategies to consider include, among others:
  - Ensuring that the updating of “Benin Nutrition Profiles” includes 2006 DHS data and other recent studies and a strengthened presentation in regards to the contributions that breastfeeding and complementary feeding have made to reductions in morbidity and mortality and socio-economic gains.<sup>49</sup> Detailed plans should be made for using powerful advocacy tool to gain commitment for a strong integrated IYCF and nutrition programme.
  - Using the BFHI “Course for Decision-makers”, the various *Lancet* series on child survival and maternal and child under-nutrition and the “Marginal Budgeting for Bottlenecks” budgeting tool for advocacy purposes.

### **Strategies for integration**

- As the most useful design for an integrated IYCF or broader nutrition programme is considered, explore the inclusion of elements of past and existing programmes such as BFHI, PMA/Nut, IMCI and IYCF, as well as the possible use of strategies and tools they have developed.
- As the design is developed, consider the key “points of contact” between nutrition programmes and the infant, child, mother, and her family, both at the facility and community levels. For example, within PMA/Nut 6 key points of contact have been identified<sup>50</sup>. This programme has at least one “point of contact” in common with IMCI – sick-child consultations. Other essential points of contact could be considered as well, such as home visits by health staff and/or peer counselors, other contacts at community level, and community contact through mass media and other IEC channels. Consider what key tasks need to be completed at each of these “points of contact”, what key actions each of the tasks would involve, who would be responsible for each of them, and what knowledge and skills are needed. Also weigh how comprehensive the integrated programme should be. It is very important to design an integrated programme that, while comprehensive, is still manageable and sustainable over time.

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<sup>49</sup> In the 2004 Profiles presentation the figures concerning what exclusive breastfeeding can contribute to “deaths averted” is lower than is probably the case, due to a lack of basic research needed to provide the data needed for the calculations of what contribution EBF makes to reduction in diarrhea disease, respiratory infections, malnutrition, and other factors. Little is presented concerning complementary feeding.

<sup>50</sup> The prenatal consultation, the delivery and immediate postpartum period, the post-natal consultation, vaccinations, well-child consultations, and sick-child consultations

- Other aspects of integrated programme development to consider include:
  - Determining how the nutrition tasks at various points of contact should be coordinated with additional health-related tasks that need to be completed at the same points. International guides concerning “integrated care” and key practices could be reviewed in the process.<sup>51</sup>
  - Emphasizing a life cycle approach to nutrition (maternal, newborn and child care, as well as a focus on adolescents). As part of this, it is essential to improve maternal nutrition. There is an urgent need to go to scale with an effective package of essential maternal nutrition interventions.
  - Ensuring that the role of optimal complementary feeding and prevention and treatment of malnutrition is highlighted in the integrated programme, as rates of stunting have been increasing in Benin. Ensuring that young children are fed nutrition-rich, low-cost and age-appropriate complementary foods should be an essential objective of a comprehensive IYCF programme.
  - Developing an evidence-based national communication for development strategy using multiple channels (with special attention to interpersonal counseling and negotiation skills). This strategy should be part of an integrated comprehensive communication strategy that encompasses health, nutrition, water and sanitation and HIV/AIDS.
  - Reviewing pre-service curricula for students (such as those in medical, nursing, midwifery and nutrition education) that will work in jobs that include IYCF-related tasks to determine how well they are currently being prepared for work in this area. The results should be used by an appropriate working group, including experts and decision-makers from the educational institutions involved, to plan for revising courses, clinical practice, and internships, so all future practitioners are provided with the knowledge and skills needed to provide up-to-date care related to IYCF as part of an integrated approach.
  - Developing an integrated training and capacity building strategy that provides staff with the knowledge and skills on IYCF needed, while being realistic concerning time and resources available for this. This strategy should address the needs for training of new staff, and refresher training and updates for those already on board, ensuring 100% coverage.
  - Developing a simple and practical system for supervision. Consideration could be given to adaptation of the supervision tools already developed by UNICEF and other organizations that focus on observation, using practical checklists focused on essential tasks for each type of activity, short exit interviews with clients, and guidelines for review and planning.
  - Developing practical evaluation strategies for gathering of data on key indicators both at baseline and selected points after programme implementation, with decision-makers, staff and community involved in ways that help assure their commitment to utilization of the findings. Strategies that allow a “management by results” focus, with retention of staff whose work really contributes to achievement of programme objectives, should be considered.
  - Considering what strategies and guidelines will be needed for coordination of the integrated programme at the various levels in a decentralized system.
  - Considering mechanisms needed to insure that the programme will be sustainable when it “goes to scale”. If national coverage is to be achieved and maintained, the integrated programme will need to be less complex than many “demonstration projects” have been in the past.<sup>52</sup> Strategic partnerships will need to be expanded as part of the effort to “scale up” IYCF interventions, with efforts to include new partners from the universities, the private sector, and civil society. Both the government and key donors will need to remain committed to full technical and financial support for a collaborative and coordinated programme over the long term.

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<sup>51</sup> Hill, Zelee et al. *Family and community practices that promote child survival, growth and development: A review of the evidence*. WHO, 2004. (<http://whqlibdoc.who.int/publications/2004/9241591501.pdf>)

<sup>52</sup> Cost-effective communication strategies could include use of community radio and tested flip charts at minimum.

## **Strengthening implementation and enforcement of the International Code**

- UNICEF and other partners such as WHO should join more actively with the MOH in the review and revision of the National Code (Decree) on the Marketing of Breast-milk Substitutes ((Decret No. 97-643) at this crucial stage. Care should be given to ensure that all essential components are included (for example, the EBF recommendation for 6 months, relevant revisions suggested in WHA resolutions, and Code provisions guiding infant feeding practices in difficult circumstances such as HIV/AIDS, emergencies, etc.).
- A study of the current practices of formula companies and the extent of violations would be useful. Plans for “revitalization” of the Code should include the designation of an active interagency Code monitoring group, guidelines for monitoring and enforcement of the Code, and needed resources.
- Consideration should be given for how to involve interested and technically competent NGOs in the monitoring process, and what support they may need for this. IBFAN, for example, could be tapped to provide very useful service, but would need on-going financial support and guidance.
- UNICEF/New York, IBFAN Africa, and the International Code Documentation Centre (ICDC) in Malaysia have resources that could be tapped as this process of revitalization of the Code continues. David Clark, the Code expert at UNICEF/NY, for example, has indicated his availability for technical support to Benin and can also suggest other useful resources.

## **Institutionalizing BFHI and strengthening support for IYCF within the health system**

- The National Coordination Committee for BFHI (which might be organized as a sub-committee of a national committee for IYCF and possibly nutrition) should be reactivated, as well as similar departmental committees. An evaluation of BFHI is planned for 2009, as part of the Annual Work Plan for the MOH, with UNICEF support. Examples of BFHI evaluations undertaken in other countries could be reviewed when designing the approach. One of the first steps of the Committee should be to thoroughly analyze the results and recommendations of this evaluation.
- As a process of revitalizing and institutionalizing BFHI is developed, possible strategies to consider include:
  - Ensuring that advocacy at policy level, both within key Ministries and at health facility level, is undertaken first to gain the understanding and commitment of key decision-makers. The “Course for Decision-makers”, part of the revised BFHI package, could be considered as one available tool that could be adapted for country use.
  - Updating BFHI training, possibly using the revised “BFHI “20-hour” Course for Maternity Services, and devising strategies for orientation and training for new arrivals and periodic refresher training, including clinical practice to keep maternity staff up to date as a critical part of the process of insuring sustainability.
  - Selecting and adapting, as necessary, streamlined tools for assessment and monitoring, so this system will be cost-effective for scale-up. The use of a new self-contained “Monitoring Tool” that is available in the revised BFHI package (Section 4.2, Annex 3), a tool for “auto-evaluation” by the health facilities themselves developed by IBFAN/Benin, and development of a computer tool for analyzing results, possibly using Excel, could be considered for use in future BFHI monitoring and/or assessment, with translation into French if not available.
  - Determining how best to organize the Initiative so that implementation of the “Ten Steps” within all maternities is fully integrated into the national health system, with full national ownership of the Initiative and on-going government support for training and monitoring, thus alleviating the need for continuing donor support. Strategies for integrating BFHI into standard operating procedures and current hospital accreditation or quality assurance mechanisms should be considered as one mechanism for insuring sustainability.

- Exploring strategies for insuring that mothers who give birth at home (currently 22% of the population) also receive needed support for successful breastfeeding. This could begin with a review of what breastfeeding support is given, currently, during home deliveries and what new knowledge and skills birth attendants and others need if fully mother and baby friendly care is to be provided.
- Strengthening key “Steps” that are currently weakly implemented, such as “Step 10” for fostering of mother support groups, and other Steps that may be identified. For Step 10, consider integrating or coordinating strategies with approaches to be used in other components in the integrated nutrition programme at community level.
- Explore strengthening of health system counseling and support for breastfeeding and complementary feeding beyond maternity facilities, through further integration of IYCF support during well-baby visits, sick child consultations, immunization sessions, growth monitoring, and other points of contact, both in hospitals and health centers at various levels.

### **Strengthening workplace support**

- Encourage and support NGOs such as IBFAN or other breastfeeding advocacy groups to work with interested employers and their workers to determine what workplace support for breastfeeding would be most useful, given women’s circumstances, implementing the suggested solutions on a trial basis. Include consideration of what can be done to address the needs of mothers who need to work during the 6 six months after delivery and can’t bring their babies to their places of employment.
- At the policy level encourage an even longer maternity leave to support exclusive breastfeeding. Consider strategies for orienting market women and others in the informal sector on how to express and store their breast milk and provide it for caregivers at home, encouraging family members to bring babies for breastfeeding, if feasible, and other strategies to promote exclusive breastfeeding.

### **Strengthening support for IYCF in difficult circumstances, including HIV and emergencies**

- Further distribute the HIV and infant feeding guidelines. The “Guide for the management of children exposed to and infected by HIV/AIDS”, produced by the MOH, could be reviewed to determine whether the section on counseling HIV positive women on infant feeding is sufficient and whether it is available to all practitioners that need it. Consideration could be given to further use of the WHO job aides for counseling HIV positive women to make appropriate feeding choices.
- Further distribute infant feeding in emergency guidelines. The international guidelines on infant feeding in emergencies could be reviewed to determine whether they meet Benin’s needs and whether all appropriate personnel have been trained in their use.<sup>53</sup>

### **Strategies for community outreach**

- Consider, when developing an integrated national nutrition programme with a strong IYCF component, how best to design the community level approaches, starting with a review of what community strategies have been used in the past and which have worked and which not, and why. Consider evidence of how best to motivate community members and staff involved in the initiatives on a long term basis, whether and how they should be compensated, etc.
- Review tools for training peer counselors and community members already available. For example, use of the simple training modules on IYCF for women in credit or other support groups developed by *Freedom from Hunger* organization could be considered. Training materials for strengthening counseling skills and use of the “negotiation” (TIPs) strategy could be helpful as well.

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<sup>53</sup> See the international guidelines and information for the media under “IFE Core Group” in the “Other Resources” section of Annex 1.

- Consider adoption of participatory strategies that involve key traditional advice-givers and decision-makers such as grandmothers in programme design and implementation, such as the approach in “The Grandmother Project”. The World Bank may arrange for the orientation workshop needed to initiate use of this approach in Benin.
- Make certain that good systems for supervision and follow-up are designed and put in place, as lack of adequate supervision has been a key failing of current community programmes. Ensure, as well, that a simple system for monitoring and evaluation is put in place. For example, if the negotiation strategy for home visits described earlier is used, changes in IYCF practices of the mothers visited could be easily tracked. This could be combined with baseline and follow-up community surveys of IYCF practices.<sup>54</sup> Consider how the outreach or peer counselors themselves can be involved in the evaluation process, without risking bias, as experience shows that when they participate actively in the evaluation, they are much more likely to use the results to improve their programmes.
- Explore how the IYCF community support can be scaled up to reach all areas of the country as part of the IYCF Action Plan. Work on this objective could start with a mapping exercise of who is doing what and where, currently, and how well the strategies are working, with the Plan then addressing how successful approaches can be realistically scaled-up and how the activities can be sustained.
- Although complementary feeding and maternal nutrition were not assessed in this evaluation, given the high rates of low birthweight and stunting, it is noted that much greater emphasis is needed on delivering an evidence-based, effective package of services to improve maternal nutrition and ensure optimal complementary feeding, as well as address the high rates of malnutrition among infants and young children. This should be a major component in future nutrition programming

### **Going to scale**

- It is essential that a detailed plan for scale-up of successful IYCF and other nutrition programming be developed, with appropriate resources, responsibilities and timeframe. The plan should build on existing cost-effective programmes and avoid verticality. Close coordination among the various partners, as mentioned earlier, is essential, with a clear set of priorities and commitment over the long term. The Government, at all levels, and the community and key decision-makers at local level, need to be involved at each step of the scale-up process.

### **The role of UNICEF in IYCF programming**

- UNICEF should play a very active role, in partnership with the MOH and other key partners, in launching the process for development of a truly collaborative, integrated national nutrition programme, with IYCF as a key component. Close collaboration with the High Council for Food and Nutrition and programme being developed with World Bank support should be considered. A working group for IYCF could be created under this umbrella (or through some other mechanism if necessary) and UNICEF, as mentioned by the UNICEF Representative, could provide critical technical and financial support for its operation.
- UNICEF should work actively, in coordination with other international organizations and donors, to advocate for both the political support and the human, technical and financial resources that will be needed over the long term for such an integrated programme. The number and types of staff well trained in nutrition at central and departmental levels would need to be substantially increased, both within the Government and within UNICEF and other agencies playing a major supportive role. If necessary, UNICEF should provide support for training the cadres needed. As UNICEF works with the Government and other partners, it needs to determine how best to ensure that IYCF actions are nationally owned and institutionalized and not perceived to be UNICEF supported projects, as BFHI was in the past.

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<sup>54</sup> The Linkages Project has developed useful community surveys and expertise is available at AED.

- UNICEF should collaborate with the Government and other partners on design and implementation of an evidence-based comprehensive communication strategy for IYCF using multiple channels.
- UNICEF should build effective partnerships with NGOs and Community Based Organizations (CBOs) and reinforce their capacities to deliver essential nutrition and health actions at the national and community levels. UNICEF could work with NGOs and CBOs in collaboration with the Government, but also work directly with these organizations to strengthen their capabilities and provide support that allows them to better contribute to an integrated IYCF programme. Additional contributions can be made by these organizations, for example, in areas such as monitoring of the Code (Decree) on the Marketing of Breast-milk Substitutes, revitalization of the BFHI, strengthening support for breastfeeding women in the workplace, community outreach, and support for mothers and children in difficult circumstance.
- UNICEF should explore the possibilities for adjusting its budgeting system so that expenditures for IYCF-related activities could be allocated, tracked and reported separately, as one component of the health and nutrition portion of its Child Survival and Development programme.

**Annexes:**

1. Materials reviewed
2. Interview schedule and contact information for key informants
3. Key IYCF Milestones in Benin

## Annex 1: Materials reviewed

### ***Demographic and Health Surveys***

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## Annex 2: Interview Schedule and Contact Information for Key Informants

### Consultation IYCF in Benin Review and Strategies for the Future

Date, time and place of interview	Name of interviewee	Organization	Position	Contact/email
3 Nov. 11h a UNICEF	Dr. Souleymane Diallo	UNICEF	Représentant	229 21 30 02 66/21 30 09 42 229 21 20 00 20 (direct) sdiallo@unicef.org
3 Nov. 15h a DSF	Dr. Alban Quenum	DSF	Directeur DSF /(229) 21 33 20 21	quenalban@yahoo.fr
3 Nov. 15h a DSF	Dr. Bernard Gbétchédji	DSF	Chef Service nutrition	
3 Nov. 15h a DSF	Mme Andréa Houindoté	DSF	Service nutrition	houindote@yahoo.fr
4 Nov. 14h a UNICEF	Dr. Raima Moudachirou	Retraitée	Ancienne chef service nutrition Coordinatrice nationale IBFAN	21330707 / 97078628 imamounachirou@hotmail.com
4 Nov. 15h a UNICEF	Dr. Hortense Ahouandjinou	ZS Cotonou 6	Ancienne chef service nutrition	21384417/95499556
4 Nov. 10 h a MS/SPS 5 Nov. 10h a l'UNICEF	Dr Dossou Victor	MS/SPS	Ancien coordonnateur BASICS	<a href="mailto:vatdossou@yahoo.fr">vatdossou@yahoo.fr</a> 90 91 48 02
5 Nov. 5 17h au MAEP	Dr. Joseph Hessou	Haut conseil de l'alimentation et de la nutrition	MAEP / consultant Chef du CORE Group / Haut conseil pour l'Alimentation et la nutrition Ancien Consultant BASICS	<a href="mailto:jedhessou@yahoo.fr">jedhessou@yahoo.fr</a> / (229) 95 06 44 22 / (229) 93 92 82 65
6 Nov. 10h – 15h en tournée	Dr Paul Adovohékpé	UNICEF	UNICEF officer and Ancien coordonnateur BASICS	padovohekpe@unicef.org
6 Nov. 11h a AO	Safe-femme	Centre de Sante Adja-Ouere	Coordonnateur de programme SMI ( ?)	
6 Nov. 11h a AO	Groupe de support des mères	Centre de Sante Adja-Ouere	Relais – mères des quartiers pour ANJE	
6 Nov. 14h a Attake	Director	Centre de Sante Attake		
6 Nov.16h a DANA	Dr. Denis Mikodè	DANA	Directeur DANA	229 22 21 26 70 95 95 58 422 (prive) admikode@yahoo.fr
6 Nov.16h à DANA	Deen Yacine	DANA	Charge des Politiques et Programmes Alimentaires et Nutritionnels	
6 Nov.16h à DANA	Marie Claude Adissin	DANA	Chef Service Formation Education Nutritionnelle et Documentation	40

6 Nov.16h a DANA	Robert Metohoue	DANA	Responsable Unité Béninoise de Technologie Alimentaire (Production d'aliments de complément du jeune infant)	
6 Nov. 16h a DANA	Antonine Oliyide	DANA	Chef Service Programmation Alimentaire et Nutritionnel	
6 Nov.16h a DANA	Pascal Adandozan	DANA	Responsable du Centre Horticole et Nutritionnel de Ouando, Chef Service Suivi-Evaluation	
	Anne Sophie le Dain	UNICEF		
7 Nov. – IYCF session	Mr Pierre Jèkinnou	Consultant	Ancien consultant BASICS (Communication)	<a href="mailto:jekinnoupm@yahoo.fr">jekinnoupm@yahoo.fr</a> 90 93 54 22
11 Nov. 10 h a Abomey	Somon Amelie	Direction de Sante, Abomey	Chef de Services des Soins Infirmiers	Tel. 95868693, 90056274
11 Nov. 10 :30 h a Abomey	Suzzane Lobotoe	Centre de Promotion Sociale d'Abomey	Chef	
11 Nov. 10 :30 h a Abomey	Melanie Allagbe (Egbo)	Centre de Promotion Sociale d'Abomey	Relai communautaire	
11 Nov. 10 :30 h a Abomey	Christiana Sossa	Centre de Promotion Sociale d'Abomey	Relai communautaire	
11 Nov. 10 :30 h a Abomey	Virginie Fiobe	Centre de Promotion Sociale d'Abomey	Relai communautaire	
12 Nov. 13 :30h a OMS	Dr. Esther Traoré	OMS	Administrateur FHP, OMS/Bénin	<a href="mailto:Traoree@bj.afro.who.int">Traoree@bj.afro.who.int</a> 90 94 72 75/ 97 29 02 55
12 Nov. 18 h a Novotel	Lina Mahy	World Bank	Nutritioniste Sante Publique, Consultant Banque Mondiale	Tel. 33(0)450403703, Cell 33683997964, <a href="mailto:rikina@yahoo.com">rikina@yahoo.com</a>
12 Nov. 18 h a Novotel	Ambroise Agbota	World Bank	Consultant Banque Mondiale	
4 Dec. 11 h a AED, Wash. D.C.	Dr. Serigne Diène	HKI ou BASICS	Ancien Conseiller Régional BASICS (Nutrition), Dakar	<a href="mailto:sdiene@smtp.aed.org">sdiene@smtp.aed.org</a>
12 Dec. 13 :30 par telephone to Freedom From Hunger	Christian Loupeda	Freedom from Hunger, Davis, CA	FFH staff member working with FECECAM and PADME in Benin	<a href="mailto:cloupeda@freedomfromhunger.org">cloupeda@freedomfromhunger.org</a>
Entrevue écrite - réponse 1 Nov.	Yaya K. Drabo	AED	Ancien Conseiller Régional BASICS (Communication), Dakar	<a href="mailto:ydafina@yahoo.fr">ydafina@yahoo.fr</a>

### Annex 3: Key IYCF Milestones in Benin

<b>1992:</b>	National policy for the protection, support and promotion of breastfeeding; and Baby Friendly Hospital Initiative (BFHI)
<b>1997:</b>	Decree on the Marketing of Breast-milk Substitutes
<b>1998:</b>	USAID-funded BASICS project introduced the ENA framework : the Nutrition Minimum Package PMA/Nut in Borgou Region
<b>2002:</b>	PMA/nut formally adopted as a national strategy
<b>2005-2008:</b>	IYCF National Strategy
<b>2009-2013:</b>	IYCF Comprehensive National Strategy
<b>2009+:</b>	Haut conseil de l'alimentation et de la Nutrition (High Council for Food and Nutrition) expected to be adopted